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ABSTRACT

By providing in-depth descriptions of the 23 promising programs available from the Program Archive on Sexuality, Health and Adolescence (PASHA), the "PASHA Program Sourcebook" offers practitioners a detailed look at "what works" to prevent pregnancy and sexually transmitted diseases/human immunodeficiency virus and acquired immune deficiency syndrome (STD/HIV/AIDS) among teens. The introductory chapter outlines the problem of teen pregnancy in the United States and discusses different approaches to address it. The remainder of the book describes each program in detail--presenting the program's theoretical framework, target population, the schedule and overview of activities comprising the intervention, and implementation guidelines. A description of the original program evaluation is also presented. By describing the programs in such depth, it is hoped the book will serve as a practical resources for those interested in learning about and developing promising prevention programs. (SLD)

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The PASHA Program Sourcebook

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Promising Teen Pregnancy and STD/HIV/AIDS Prevention Programs

UD032762

PASHA

The Program Archive on Sexuality, Health & Adolescence

Supported by a grant from US Office of Public Health and Science, Office of Population Affairs

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The PASHA Program Sourcebook

Promising teen pregnancy and STD/HIV/AIDS prevention programs

Edited by

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Table of Contents

Acknowledgements

Executive Summary i

Introduction 1

Chapter 1 Human Sexuality—Values & Choices: A Values-Based Curriculum for 7th and 8th Grades 21

Chapter 2 Project TAKING CHARGE 39

Chapter 3 Reducing the Risk—An Adolescent Pregnancy & STD/HIV/AIDS Prevention Program 57

Chapter 4 Reproductive Health Counseling for Young Men 73

Chapter 5 School/Community Program for Sexual Risk Reduction 87

Chapter 6 School-Linked Reproductive Health Services (The Self Center) 107

Chapter 7 Tailoring Family Planning Services to the Special Needs of Adolescents: New Adolescent Approach Protocols 131

Chapter 8 Teen Talk 151

Chapter 9 A Health Care Program for First-Time Adolescent Mothers and their Infants 169

Chapter 10 Queens Hospital Center's Teenage Program 183

Chapter 11 Adolescents Living Safely: AIDS Awareness, Attitudes, and Actions 201

Chapter 12 Adolescents Living Safely: AIDS Awareness, Attitudes, and Actions for Gay, Lesbian & Bisexual Teens 223

Chapter 13 AIDS Prevention and Health Promotion among Women 245

Chapter 14 AIDS Prevention for Adolescents in School 259

Chapter 15 ARREST: AIDS Risk Reduction Education & Skills Training Program 273

Chapter 16 AIDS Risk Reduction for College Students 287

Chapter 17 A Clinic-Based AIDS Education Program for Female Adolescents 305

Chapter 18 Get Real about AIDS® 317

Chapter 19 Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth 335

Chapter 20 Rikers Health Advocacy Program (RHAP) 353

Chapter 21 Safer Sex Efficacy Workshop 367

Chapter 22 Youth AIDS Prevention Project (YAPP) 381

Chapter 23 Youth and AIDS Project's HIV Prevention Program 401

Order Form 417

Acknowledgements

Original Developers

For the present volume, as well as other PASHA-related resources, Sociometrics remains indebted to the work of the original developers of the programs in the PASHA collection. Here, we list the program names and their original developer(s). The collection is further described in the Introduction and in the 23 chapters of this book.

	Program Name	**Original Developer(s)**
Pregnancy Prevention Programs	Human Sexuality—Values & Choices: A Values-Based Curriculum for 7th and 8th Grades	Search Institute
	Project TAKING CHARGE	American Association of Family and Consumer Sciences
	Reducing the Risk	Richard Barth, M.S.W., Ph.D.
	Reproductive Health Counseling for Young Men	Ross Danielson, Shirley Marcy, Anne Plunkett, William Wiest & Merwin Greenlick
	School/Community Program for Sexual Risk Reduction among Teens	Murray Vincent, Ed.D.
	School-Linked Reproductive Health Services (The Self-Center)	Laurie Schwab Zabin, Ph.D., Janet B. Hardy, M.D.C.M., & Rosalie Streett, M.S.
	Tailoring Family Planning Services to the Special Needs of Adolescents: New Adolescent Approach Protocols	Lynn Cooper Breckenmaker & Laraine Winter, Ph.D.
	Teen Talk	Marvin Eisen, Ph.D., Alfred McAlister, Ph.D. & Gail Zellman, Ph.D.
Secondary Pregnancy Prevention Programs	A Health Care Program for First-time Adolescent Mothers and their Infants	Ann L. O'Sullivan, Ph.D., F.A.A.N.
	Queens Hospital Center's Teenage Program	Jill M. Rabin, M.D. & Vicki Seltzer, M.D.

STD/HIV/AIDS Prevention Programs

Adolescents Living Safely: AIDS Awareness, Attitudes and Actions	Mary Jane Rotheram-Borus, PhD., Sutherland Miller, Ph.D., Cheryl Koopman, Ph.D., Clara Haignere, Ph.D., & Calvin Selfridge
Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens	Sutherland Miller, Ph.D., Joyce Hunter, D.S.W., & Mary Jane Rotheram-Borus, Ph.D.
AIDS Prevention and Health Promotion Among Women	Stevan E. Hobfoll, Anita P.Jackson, Justin Lavin, Paula J. Britton & James B. Shepherd
AIDS Prevention for Adolescents in School	Heather J. Walter, M.D., M.P.H., & Roger D. Vaughan, M.S.
ARREST: AIDS Risk Reduction Education and Skills Training Program	Michele D. Kipke, Ph.D.
AIDS Risk Reduction for College Students	Diane L. Kimble-Wilcutts, Jeffrey D. Fisher, Ph.D., William A. Fisher, Ph.D. & Stephen J. Misovich, Ph.D.
A Clinic-Based AIDS Education Program for Female Adolescents	Vaughn I. Rickert, Psy.D., Anita Gottlieb, R.N.P. & M. Susan Jay, M.D.
Get Real About AIDS®	Comprehensive Health Education Foundation
Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth	New England Research Institues and Hispanic Office of Planning & Evaluation
Rikers Health Advocacy Program (RHAP)	Stephen Magura, Ph.D., Janet L. Shapiro, M.A. & Sung-Yeong Kang, Ph.D.
Safer Sex Efficacy Workshop	Karen Basen-Engquist, Ph.D., M.P.H.
Youth AIDS Prevention Project (YAPP)	Susan R. Levy, Ph.D., Brian R. Flay, D. Phil & Arden S. Handler, Dr.P.H.
Youth and AIDS Project's HIV Prevention Program	Gary Remafedi, M.D., M.P.H., Susan Reynolds, M.S.W., John Yoakam, M.Div., & Kevin Cwayna, M.D.

EXECUTIVE SUMMARY

The United States has the highest teen birth rate in the developed world. However, for the most recent period for which national statistics are available (1991-1996), the teen birth rate has exhibited a steady decline. We cannot say with certainty why it has been dropping. Several explanations have been put forward, including a rise in the popularity of abstinence (an increase in the proportion of teens choosing not to have sex) as well as an increase in contraceptive use among sexually active teens. Because of the complex factors that contribute to high teen birth rates, several hundred different teen pregnancy prevention programs—from "just say no" approaches to more general youth development approaches—have been developed and implemented. Of course, the question asked by community leaders, service providers, practitioners, legislators, policymakers, funders, and researchers, alike, is "Have these programs contributed to the decline in teen births?" And, if so, "what works" to prevent pregnancy and STD/HIV/AIDS among teens?

To help answer these questions, we created the PASHA Program Sourcebook: Promising Teen Pregnancy and STD/HIV/AIDS Prevention Programs. This Sourcebook provides in-depth descriptions of 23 programs in the Program Archive on Sexuality, Health and Adolescence (PASHA). PASHA is a public-use archive comprised of programs judged by a Scientist Advisory Panel to have been effective in changing sexual risk-taking behavior in youth in at least one site. The programs are diverse in terms of their population of interest, their approach, and their components. Viewing them as a group has led to some notion of "what works" in preventing teen pregnancy and teen STD/HIV/AIDS.

The Sourcebook begins with an introductory chapter, *Teen Pregnancy Prevention: Do Any Programs Work?*, which describes the problem of teen pregnancy in the United States, presents different ways of framing the problem, and then outlines possible solutions to the problem. One of the primary solutions presented in this introductory chapter is the replication and re-evaluation of effective prevention programs. Twenty-three of these effective programs comprise the focal point for the remaining chapters of the Sourcebook.[1] Each chapter describes one of the primary pregnancy prevention, secondary pregnancy prevention, or STD/HIV/AIDS prevention programs in PASHA, along with a summary of the evidence for their effectiveness.

In answering the question, "what works," it is important to understand the details of each of these programs. These details are essential, because it is not a generic program, e.g., a "school-linked clinic," that works; rather, it is a *particular* school-linked clinic with its particular set of associated counseling and outreach activities that is successful. To that end, each chapter provides information regarding the program's target population, the schedule and nature of activities comprising the intervention, and requirements for implementing the program. A description of the original program evaluation, including how the evaluation was designed and what the evaluation results showed, is also presented.

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[1] A total of 30 teen pregnancy and STD/HIV/AIDS prevention programs were selected by the Scientist Expert Panel for inclusion in PASHA. Of this group, 23 chose to participate and are therefore highlighted in this Sourcebook. References for the seven non-participating programs are provided in the table on pages 10-13.

While the effects of these programs have, for the most part, been modest, they likely have been at least a partial contributor to the country's focus on the problem of teen pregnancy—a focus that has led to the sixth straight year of decline in the teen birth rate. Prevention program developers would be well advised to include these components of effective programs in future prevention programs. We hope the PASHA Program Sourcebook will be a helpful resource for individuals interested in learning about and developing promising prevention programs.

INTRODUCTION

Teen Pregnancy in the U.S.: Statement of the Problem

Teen mothers are less likely to complete high school than their classmates. They are also more likely to end up on welfare. The children of teen mothers have lower birth weights, are more likely to perform poorly in school, are at greater risk of abuse and neglect, are more likely to be placed in foster care, more likely to engage in criminal activity as adolescents and young adults, and less likely to be economically and socially successful as adults. Daughters of teen mothers are more likely to repeat the cycle and themselves become teen mothers [38, 47, 49, 52]. While recent research suggests that these multidimensional educational, occupational, health, and social consequences are not as deleterious as has long been thought, the adverse effects are real. Adolescent parenting results in a loss of individual human potential. There are also economic and social costs to teen childbearing. In 1990, the government spent more than $25 billion for social, health and welfare services to families begun by teen mothers [51].

Severity

The United States has the highest teen birth rate in the developed world. Teen birth rates in the U.S. are four times those in the countries of the European Union. A cross-national study of six industrialized countries showed the U.S. teen pregnancy rate to be higher, as well, than that of Canada, England and Wales, France, the Netherlands, and Sweden. These country differences in teen birth and pregnancy rates are not due to differences in the proportion of married teens in the U.S. versus Europe; the same conclusions would apply if only unmarried teens were looked at. Similar conclusions would also be reached if comparisons were restricted to white teens only. The proportion of sexually active (non-virgin) teens is likewise similar across the industrialized countries, with the exception of Sweden, where higher proportions of teens are sexually active at every age. Thus, earlier or more frequent sexual activity among U.S. teens is not the cause of the higher teen pregnancy and birth rates in the U.S. What then accounts for these rates? The answer lies in differences in contraceptive use patterns among sexually active teens. American teenagers are less likely to use contraceptives when having sex than are their European counterparts. Those American teens who do use contraceptives are less likely to use effective contraceptives such as the pill. They are also less likely to use contraceptives with regularity [72].

Trends

The U.S. birth rate among teens age 15 to 19 declined steadily from 1970 to 1978, rose slightly in the 1978-1983 time period, declined to a record low of 50.2 births per 1,000 females age 15-19 in 1986, and then rose again to a peak rate of 62.1 in 1991. Of note, however, is that over the most recent period for which national statistics are available (1991-1996), the rate has exhibited a steady decline. The birth rate to U.S. females age 15 to 19 was 54.7 in 1996, 12% less than the 1991 peak rate of 62.1 per 1,000, but not yet as low as the 1986 record-low rate of 50.2. The decline in the teen birth rate was sharpest for black teens: a 21% drop from 1991 to 1996, according to the National Center for Health Statistics.[49, 73]. Although black teens still have almost twice the birth rate of white teens, they now have a lower birth rate then Hispanic teens.

We cannot say with certainty why the teen birth rate has been dropping. Several explanations have been put forward, including a rise in the popularity of abstinence (an increase in the proportion of teens choosing not to have sex) as well as an increase in contraceptive use among sexually active teens. In part because of the AIDS scare, use of condoms among sexually active teens has risen fourfold in the last 15 years, from 11% to 44%. In addition, inner-city teenagers are increasingly using the highly effective Depo-Provera injections or Norplant.

While undoubtedly cause for celebration, the recent decline in the teen birth rate should be treated with only cautious optimism, however, for two reasons. First, the lower teen birth rate has been accompanied by increasing proportions of *unmarried* teens among the group of teen mothers. For example, in 1994 76% of teen mothers were unmarried. Fourteen years earlier, in 1960, only 15% of teen mothers were unmarried. [51] This higher proportion of out-of-wedlock births among teen mothers likely reflects changing social values—the generally greater acceptability of out-of-wedlock childbearing in the U.S.—as it mirrors a similar increase in out-of-wedlock childbearing among older American women.

Also tempering the celebration over the recent decline in the teen birth rate is the continuing high incidence of sexually transmitted infections (Studs) among U.S. adolescents. The incidence of STDs among adolescents increased rapidly in the 1960s and 1970s, and remained at high levels in the 1980s and 1990s despite the profusion of AIDS prevention messages. One fourth of all STI cases in the U.S. occur to teenagers. In the 1980s and 1990s, gonorrhea infection rates fell among older age groups in the U.S. but remained constant among teens; rates for chlamydia are at least double those of gonorrhea. The number of visits of teenage women to office-based fee-for-service practices for genital herpes infections increased over six-fold from 15,000 in 1966 to 100,000 in 1995. The number of visits by teen women for genital warts caused by the human papilloma virus (HPV) quadrupled from 50,000 in 1966 to approximately 200,000 in 1995. [72] Clearly, adolescents' sexual behavior puts them at risk not only for pregnancy but for sexually transmitted infections as well.

Antecedents

Broad social and environmental factors such as poverty and social disorganization—high residential turnover, high divorce rates, poor parental support and supervision—put teens at risk of teen pregnancy. Individual characteristics such as are poor school performance, low expectations for the future, high aggression, difficulty getting along with peers, and early puberty development make particular teens additionally vulnerable [38]. Both sets of factors need to be taken into account in developing strategies to address the problem.

WHAT HAS BEEN DONE ABOUT THE PROBLEM?

A Historical View

Largely as a result of the research findings on the negative consequences of teen pregnancy and parenthood, "care" programs for pregnant teens, teen mothers, and their infants proliferated in the 1970s. These programs generally provided comprehensive pre- and post-natal health services for the young mother and her child. The pre-natal programs were very helpful in attenuating, often even preventing, the negative consequences of teen parenthood for the health of the infant. Many care programs also helped the teen mother stay in or return to school by providing special classes for these moms and/or day care for their children.

In the early 1980s, program planners began to look more to "prevention" as an effective way to address the problems of teen pregnancy and parenthood. New programs aimed at preventing the occurrence of the early pregnancy or birth began to emerge. A variety of different approaches were tried, based on the research literature on antecedents of the problem as well as on program planners' ad hoc or ideologically-based ideas about acceptable and effective means of preventing pregnancy [48]. Among the approaches tried were:

- *'just say no'* approaches, which teach young people the benefits of abstinence and the skills to refuse unwanted advances;
- *sex education* approaches, which focus on teaching teens about the reproductive process and STDs, how to avoid getting pregnant—using abstinence or contraception, how to avoid getting STD/HIV/AIDS;
- *contraceptive provision* approaches, which facilitate access to contraception by the sexually active (e.g., by establishing community-based family planning clinics, school-based or school-linked health centers that dispense contraception, condom distribution locations in schools and communities);
- more general *life option* or *youth development* approaches—programs with broader activities such as academic remediation, job training, or adult mentoring, which are founded on the premise that the belief in a compelling personal future or goal is a strong incentive to avoid teen pregnancy; and
- *multiple-component* programs composed of two or more of the above approaches.

In the 1990s, several new approaches to the problem emerged.

A RENEWED EMPHASIS ON ABSTINENCE. Many schools and communities have rallied around the call for a return to the "old days" when abstinence until marriage was the expectation and the norm. Proponents of the abstinence-only approach give two primary reasons for the correctness of their approach: first, it is immoral to have sex outside marriage; second, abstinence is the most effective way to prevent both pregnancy and STDs.

A POSITIVE VIEW OF TEEN SEXUALITY. At the opposite end of the spectrum, other schools and communities have attempted to refocus the issue away from the prevailing "problem" or "disease" model of teen sexuality and pregnancy to the more positive challenge of how a nation teaches its children what healthy and responsible sex means in the adolescent years [53]

STD/HIV/AIDS PREVENTION PROGRAMS. In response to the AIDS and STD epidemics, many programs have been developed that are aimed at preventing not only pregnancy among teens, but STD/HIV/AIDS as well. Some of the STD/HIV/AIDS prevention programs are aimed at the general population of youth and stress the importance of abstaining from sex, or using STI-protection (a condom) when having sex. Other STD/HIV/AIDS prevention programs are designed for high-risk, sexually active populations of youth such as gay and bisexual youth, runaways, drug-abusing youth, and incarcerated teens. These programs focus on "safer sex," teaching teens how to assess the riskiness of their sex-related behaviors and then lower such risk levels.

COMMUNITY-WIDE INITIATIVES. Another recent development has been an increase in the scale of teen pregnancy prevention programs. Because, as described previously, teen pregnancy is brought about by a constellation of societal and individual factors, many communities have begun to embark on community-wide teen pregnancy prevention initiatives aimed at addressing teen pregnancy in the context of the larger social issues surrounding the problem. Collaboratives composed of schools, community groups, and family planning clinics are being established to coordinate these efforts within the community. The Centers for Disease Control and Prevention (CDC) has awarded cooperative agreements to 13 community-wide coalition partnership programs to demonstrate that community partners, in communities with a population of 200,000 or more, can mobilize and organize community resources in support of community-wide, comprehensive, risk-specific, effective, and sustainable programs for the prevention of initial and repeat teen pregnancies. The community-wide coalition partnership programs are located in the following cities: Boston, Massachusetts; Chicago, Illinois; Jacksonville, Florida; Kansas City, Missouri; Milwaukee, Wisconsin; Oklahoma City, Oklahoma; Philadelphia, Pennsylvania; Pittsburgh, Pennsylvania; Rochester, New York; San Antonio, Texas; San Bernardino, California; Winter Park, Florida; and Yakima, Washington [9].

YOUTH-DEVELOPMENT PROGRAMS. Another approach to addressing the larger societal factors surrounding teen pregnancy has come in the form of a newly emerging interest in "youth development" programs which begin intervening at an early point in the life of a child (e.g., junior high school, or even elementary school), include components that go beyond teaching abstinence or contraception (e.g., academic remediation, job training), and have goals that go beyond preventing teen pregnancy (e.g., increasing rates of graduation from high school, enhancing post-graduation employment opportunities). These programs' relationship to teen pregnancy emanates from the belief that "the best contraceptive is a bright future."

STATE AND LOCAL GOVERNMENT INITIATIVES. State and local governments have taken an increasingly active role in tackling the problem of teen pregnancy. Initiatives have come in the form of sex education and statutory rape laws and the sponsoring of media campaigns with a variety of messages promoting teen pregnancy prevention, such as: "You can go farther when you do not go all the way." "You play, you pay." (North Carolina, Maryland) "A child is too important to leave to chance." "Don't kid yourself." (Montana) "It's okay, even cool, to say no to sex." (New York) [52]

THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY. With encouragement from President Bill Clinton, the privately-funded National Campaign to Prevent Teenage Pregnancy was founded in 1996. The Campaign's mission is to prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence. Its goal is to reduce the teen pregnancy rate by one-third by the year 2005. Working through a group of five Task Forces, the Campaign has five primary components: (1) taking a strong stand against teen pregnancy and attracting new and powerful voices to this issue; (2) enlisting the help of the media; (3) supporting and stimulating state and local action; (4) leading a national discussion about the role of religion, culture, and public values in an effort to build common ground; and (5) making sure that everyone's efforts are based on the best facts and research available [52]. In the two years since its formation, the Campaign has put together an impressive array of diverse and powerful voices, conferences, focus groups, and print and audiovisual material aimed at teen pregnancy prevention.

FRAMING THE PROBLEM AND POSSIBLE SOLUTIONS

Before the question "What works?" can be addressed, the question "To solve what problem?" needs to be answered. A major challenge for the National Campaign to Prevent Teen Pregnancy, indeed for the country as a whole, lies in the lack of consensus about what the problem is, indeed on whether the country has a problem to begin with. Ongoing, occasionally contentious, national debate has centered on framing the problem and its possible solutions.

Is There a Problem?

There are those who believe that the nation has erred in focusing energy and attention on teen sexual behavior, pregnancy, and parenthood. The real problem, they assert, is poverty. To back up their position, they provide evidence that early research on the consequences of teen pregnancy for mother, father, and infant overstated teen parenthood's deleterious educational, occupational, health, social, and societal consequences. These deleterious consequences, attributed to teen pregnancy by early research, were (and still are) problems brought about by antecedent factors common to both teen pregnancy and the negative consequences: poverty and social disorganization. More recent research has done a better job of controlling statistically for these common antecedents of teen pregnancy, school failure, unemployment, etc. For the most part, the deleterious effects attributed to teen pregnancy have held up. Most segments of society are now willing to concede that teen parenthood has negative personal consequences for mother and child as well as cost consequences for society, though these deleterious effects may not be as severe as was once thought.

What is the Problem?

A more major and contentious debate centers on the outcome variable, the "problem" that we as a nation should address. A vocal minority say that too-early *sex* is the problem. A greater number say that the problem is not sexual activity among teens but rather too early *pregnancy*. Yet others believe that it is not sex or pregnancy per se, but rather *out-of-wedlock* sex or pregnancy, *forced* sex, or *unintended* pregnancy that is the problem. Finally, there are those who are of the opinion that teen *childbearing* lies at the heart of the problem: only teen pregnancies carried to term bring about the deleterious consequences that research has documented.

What Is the Solution?

The way the problem is framed is crucial because such framing determines the possible solutions. It determines "what works" to solve the problem. Those who believe that unmarried sex by teenagers is the problem press for "abstinence-only" approaches to solving the problem. Contraceptive-related approaches to reducing the U.S. teen pregnancy rate cannot be considered. These approaches are morally unacceptable because they condone unmarried teen sex, an immoral activity. Those who believe that teen pregnancy is the heart of the problem embrace both abstinence and contraception approaches to solving the problem. Since unprotected sexual intercourse is what leads to pregnancy, whatever works to reduce such unprotected sex is where the focus of attention should be. Both abstinence and contraception approaches are laudatory as they work in tandem to reduce the teen pregnancy rate. For those who assert that it is teen parenthood that lies at the heart of the problem (because the negative consequences of teen pregnancy have been documented only for the group of teens who carry their pregnancy to term) whatever works to reduce the teen birth rate should be considered and made available to all teens: abstinence-focused intervention programs, contraception-focused intervention programs, even abortion services. Finally, for those who continue to believe that the heart of the problem lies not in teen sex, pregnancy, or parenthood but rather in poverty, youth development approaches that emphasize skill building, future planning, and adult involvement more than sexuality or pregnancy are the solutions of choice.

Toward an Eclectic Approach to Framing the Problem and Possible Solutions

In 1998, the National Campaign to Prevent Teen Pregnancy presented an award to the California communities of Bloomington and Colton, near San Bernardino, for a program that brought together the most socially conservative and the most socially liberal to find common ground on preventing teen pregnancy. The San Bernardino approach provides a model for an eclectic, inclusive approach to framing and solving the problem of teen pregnancy. With an inclusive approach, all stakeholders within a community, regardless of their views on the problem or its solutions, are encouraged to talk to one another, with the goal of finding common ground when they can and agreeing to disagree when they cannot. When common ground can be found among stakeholders, a coherent and integrated approach to preventing pregnancy can be organized within the community. When common ground cannot be found, programs with different approaches can co-exist within the same community. The important thing, in either instance, is to ensure that: (1) pregnancy prevention initiatives and programs are consistent with the values and beliefs of the segment(s) of the community in which they are implemented; (2) all efforts incorporate components that have been found to be part of effective programs (see the next section), and (3) all stable efforts (ones that have been in place for a couple of years) be evaluated for effectiveness, with appropriate modifications made in response to the evaluation.

WHAT WORKS?

Evaluation Methods

An important development of the 1990s has been the growing acceptance—among community leaders, service providers, practitioners, legislators, policymakers, funders, and researchers alike—of the importance of conducting scientific evaluations of the effectiveness of teen pregnancy prevention programs. Growing consensus has emerged that program development should be guided not only by what might or should work (based on moral, ideological, personal, or political beliefs) but on what does work (based on rigorous scientific evaluation). This acceptance of evaluation's importance in shaping and strengthening programs was slow in coming. Although by 1990 several hundred teen pregnancy prevention programs had been developed and implemented, few good evaluations existed. A variety of reasons underlay this dearth of scientifically valid program evaluations [7]. First there were the tensions, some more real than others, between service and science. Service providers were often reluctant to direct dollars that could go toward helping those in need to scientific endeavors whose benefits were (perhaps erroneously) perceived as relatively remote. In addition, both funders and service providers were understandably wary about possible fallout from negative evaluations. Beyond this, some funders felt constrained by fact or politics from providing support for approaches not in line with their mission or their legislative mandate. As the national debate grew over related issues such as abortion and the provision of contraception to minors, powerful institutions such as schools became increasingly reluctant to ally themselves with controversial issues such as school-based clinics, or contraceptive education and provision.

There were also tensions between the requirements of science and the realities of program administration. For example, scientific evaluation encouraged the random assignment of subjects to treatment and control groups; administrators often replied that it was unacceptable to withhold treatment from those in need, especially when the funds were available to provide the service. Scientific rigor demanded that baseline and follow-up data be collected from identifiable individuals so that these data could be linked; administrators often replied that, for cost and confidentiality reasons, this could not be done. Moreover, when a good evaluation was designed and implemented, it was often discovered that members of the control or comparison group had been exposed to the influence of competing similar programs, thus allowing only for a very conservative test of the program's effectiveness.

Despite these obstacles, the field made laudable progress in the 1990s. Consciousness about the importance of evaluation has been raised. Evaluation instrumentation has advanced. Today the field is more aware of the technical challenges of program evaluation, as well as the costs and benefits associated with various research designs. Moreover, the ways in which evaluation data may serve to improve prevention programs are now appreciated and understood. [72]

Hand in hand with the slow but inexorable acceptance of evaluation's importance has come a wave of publications reviewing the evidence for the effectiveness of existing teen pregnancy prevention and teen STI/HIV/AIDS prevention programs [3, 8, 22, 23, 26, 30, 35, 37, 38, 40, 48, 50, 59, 79]. The consensus of these reviews is that the state of evaluation research on teen pregnancy prevention programs, while improved, still has a ways to go before definitive findings can be touted. Problems with the state-of-the-art range from a dearth of evaluated programs, methodological problems among the evaluations actually conducted, inconsistent results reported by published evaluations, and the dearth of replications of even the most promising programs [38]. Despite these limitations, characteristics of effective programs have begun to emerge from the literature.

Evaluation Results

"What works" in preventing teen pregnancy can be analyzed in three ways. (1) Which of the general approaches to the problem—abstinence-only, sex education, contraceptive provision, youth development, multi-component, community-wide initiative—appear to be the most promising? (2) What are the characteristics, or common components, of effective programs? (3) Which individual prevention programs appear to be the most promising and deserving of replication and re-evaluation?

EFFECTIVENESS OF THE VARIOUS APPROACHES TO PREVENTING TEEN PREGNANCY. Most existing reviews have used this frame—assessing the effectiveness of one or more approaches to preventing teen pregnancy—for answering the question "what works." According to these reviews, the jury is still out on abstinence-only programs. While the weight of the evidence is that these programs do not delay the onset of intercourse as intended, methodological flaws with existing evaluations warrant a wait-and-see approach. The Personal Responsibility and Work Opportunity Act of 1996, which was signed into law by President Clinton on August 22, 1996, contains a provision that will provide $50 million in annual matching grants to states for abstinence-only programs, beginning in 1998. All 50 states have applied for these funds. Congress has allocated $6 million for a national evaluation of these "abstinence until marriage" education programs. [79] Hopefully, the field will be able to make some definitive statements about the effectiveness of the abstinence-only approach in about three years time. Most evaluated programs have fallen under the more general sex education approach—programs that discuss abstinence, contraception, as well as STI/HIV/AIDS. Some of these programs have been shown to be successful in delaying the onset of intercourse, reducing the number of sexual partners, and/or increasing the use of contraceptives such as condoms. Others have not. The evidence for the effectiveness of contraceptive provision, youth development, and multiple-approach prevention programs has likewise been mixed. Similarly, the jury is still out on whether community-wide initiatives "work." The methodological challenges inherent to the evaluation of large, community-wide initiatives are only now beginning to be sorted out. It should be pointed out that there is an inherent weakness to addressing the "what works" question in terms of these general approaches to solving the teen pregnancy problem. Given the wide variety of programs that could fall under each approach—programs differing in intensity, duration, components or pedagogical approaches used, age and level of risk of the target population—the most likely (indeed, perhaps the only)—conclusion of any analysis will be one of apparent inconclusiveness and inconsistency. Some programs using Approach A work, others do not. Some programs using Approach B work, others do not. The inconclusiveness is built into the way the analysis is framed in the first place. Within any given type or approach, there will be "strong" programs and there will be "weak" programs. No one approach can be expected to yield anything other than mixed results. Thus, the second and third ways (below) of trying to determine "what works" are more appropriate ways of framing the question and more likely to lead to useful answers: Do effective programs share common characteristics? Are there individual programs that have been successful in documenting sexual or contraceptive behavior change in participants?

CHARACTERISTICS OF EFFECTIVE PROGRAMS. Programs that show modest behavioral effects share nine important characteristics, according to a recent review commissioned by the Effective Programs and Research Task Force of the National Campaign to Prevent Teen Pregnancy. They (1) focus clearly on reducing one or more sexual behaviors that lead to unintended pregnancy or STI/HIV/AIDS infection; (2) incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of students; (3) are based upon theoretical approaches that have been demonstrated to be effective in influencing other health-related risky behaviors; (4) last long enough to allow participants to complete important activities; (5) provide basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse; (6) employ a variety of teaching methods designed to involve the participants and have them personalize the information; (7) include activities that address social pressures related to sex; (8) provide models of and practice in communication, negotiation, and refusal skills; and (9) select teachers or peers who believe in the program and then provide them with training, which often includes practice sessions. [38]

Another recent review [8] used an Expert Panel of noted scientists in the field to examine the evidence for effectiveness of existing teen pregnancy and STI/HIV/AIDS prevention programs and then prioritize such programs in terms of their documented impact on one or more of 13 outcome variables related to teen pregnancy and STI/HIV/AIDS prevention: (1) postponing sexual intercourse; and, for already sexually active teens: (2) decreasing the frequency of sexual intercourse; (3) decreasing the number of sexual partners; (4) increasing contraceptive use at first intercourse; (5) increasing contraceptive use at most recent intercourse; (6) increasing consistent contraceptive use among the sexually active at every intercourse; (7) preventing pregnancy; (8) increasing use of effective STI/HIV/AIDS-prophylactic method at first intercourse; (9) increasing use of effective STI/HIV/AIDS-prophylactic method at most recent intercourse; (10) increasing consistent use of effective STI/HIV/AIDS-prophylactic method at every intercourse; (11) substituting lower-risk sexual behaviors for high-risk behaviors; (12) increasing STI/HIV/AIDS prevention-related behaviors such as increased condom purchasing, increased voluntary condom carrying; and (13) preventing STDs/HIV/AIDS. For programs aimed at children 15 or younger, demonstrated, positive impact on fertility-related and/or STI/HIV/AIDS-related refusal/negotiation skills, intentions, values and attitudes was accepted as preliminary evidence of the program's promise. Using these criteria, 30 programs—11 primary prevention programs aimed at preventing a first pregnancy, 4 secondary prevention programs aimed at preventing a second pregnancy, and 15 STI/HIV/AIDS prevention programs—were judged worthy of inclusion in a collection of prevention packages for public dissemination and use known as PASHA, the Program Archive on Sexuality, Health and Adolescence.

The approaches and components of the 30 exemplary PASHA programs provide insight into "what works." The term "approach," as used here, refers to the general rationale or theory of behavioral change guiding the intervention. Eight approaches were discerned in the PASHA collection: abstinence, behavioral skills development, community outreach, contraceptive access, contraceptive education, life option enhancement, self efficacy/self esteem, and sexuality/STI/HIV/AIDS education. "Components," in contrast, represent the more specific instructional methods or techniques used in program delivery. Eight primary components were found in the PASHA collection: adult involvement, case management, group discussion, lectures, peer counseling/instruction, public service announcements, role play, and video. Analyses of the former dimension found that the use of multiple approaches was common in effective programs. On average, programs in the collection incorporated four different approaches. One broad-based community-wide intervention (*School/Community Program for Sexual Risk Reduction among Teens*) included all eight. Three approaches were found in nearly all (over 90%) of the 30 interventions: (1) behavioral skills development (e.g., practicing saying "no" to unwanted sex, practicing how to avoid risky situations, practicing how to purchase a condom, negotiating condom use with a sexual partner); (2) contraceptive education; and (3) sexuality education. Ten of the 30 PASHA programs provide participants with access to contraceptives. Eight emphasized improving self-efficacy. Finally, abstinence was promoted as the preferred, but not exclusive, choice for adolescents in eight programs.

With respect to the program components dimension, it was found that four methods or techniques for program delivery predominated: group discussions (used in 25 programs), lectures (21 programs), role plays (20 programs), and videos (14 programs). Of the remaining components, adult involvement (such as special evening sessions introducing parents to school-based programs and encouraging communication with their children regarding sexuality) was most often used in primary pregnancy prevention programs. Case management was common within secondary pregnancy prevention programs, where mothers receive a broad array of services matched to their specific educational, social, and psychological needs. Finally, drawing upon principles of Social Learning Theory, a few primary pregnancy and STI/HIV/AIDS programs invited specially trained adolescents to serve as peer counselors or leaders, thus aiming to provide persuasive and powerful role models for participants.

Two measures of program intensity were investigated: the number of sessions and the total length of the intervention. Here tremendous variability was found within the PASHA effective-program collection. For example, two STI/HIV/AIDS prevention programs relied on single session workshops, lasting between one and three hours, while the clinic-based secondary pregnancy prevention programs typically offered mothers a multiplicity of services from pregnancy through their 20th birthday. Programs directed to high-risk youth (e.g., gay and bisexual teens, runaways) were relatively more intense, perhaps involving 30-40 hours of participation. In contrast, programs directed toward a wider audience, often implemented in family life education programs, typically spanned a few weeks but involved only 5 to 15 hours of instruction. [8]

EXAMPLES OF PROMISING PROGRAMS. The 30 promising programs selected by a Scientist Expert Panel for inclusion in PASHA are listed below, along with the program developers. They are categorized according to program focus (i.e., primary pregnancy prevention, secondary pregnancy prevention, STD/HIV/AIDS prevention). The programs with a star (*) by them chose to participate in the archive and are, therefore, described in the ensuing chapters. The complete sets of materials needed to implement the 23 starred programs are available from the public-use PASHA archive.[1]

The 11 Promising Primary Pregnancy Prevention Programs

Program Name	Program Developer(s)	Chapter Describing Program	References
Adolescent Compliance in the Use of Oral Contraceptives	*M.Susan Jay,Robert H. DuRant, Tamsen Shoffitt, Charles W. Linder, and Iris F.Litt*	Not Applicable	31
***Human Sexuality—Values & Choices: A Values-Based Curriculum for 7th and 8th Grades**	*Search Institute*	1	13
Postponing Sexual Involvement (PSI)	*Marion Howard and Judith Blamey McCabe*	Not Applicable	11, 27, 28, 29
****Project TAKING CHARGE***	*American Association of Family and Consumer Sciences*	2	33, 34
****Reducing the Risk***	*Richard Barth*	3	4, 5, 39
****Reproductive Health Counseling for Young Men***	*Ross Danielson, Anne Plunkett, Shirley Marcy, William Wiest and Merwin Greenlick*	4	12

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[1] Write Program Archive on Sexuality, Health & Adolescence, Sociometrics Corporation, 170 State Street, Suite 260, Los Altos, CA 94022. Or call: (650) 949-3282, ext. 236. Or use the Order Form at the back of this book.

School/Community Program for Sexual Risk Reduction among Teens	*Murray Vincent*	5	12
****School-Linked Reproductive Health Services (The Self Center)***	*Laurie Schwab Zabin, Janet B. Hardy, and Rosalie Streett*	6	10, 24, 81, 82, 83
****Tailoring Family Planning Services to the Special Needs of Adolescents: New Adolescent Approach Protocols***	*Lynn Cooper Breckenmaker and Laraine Winter*	7	80
Teen Outreach	*Association of Junior Leagues International and Cornerstone Consulting*	Not Applicable	1, 2, 58
****Teen Talk***	*Marvin Eisen, Alfred McAlister, and Gail Zellman*	8	14, 15, 16, 17, 18, 19, 20

The 4 Promising Secondary Pregnancy Prevention Programs

Program Name	Program Developer(s)	Chapter Describing Program	References
Elmira Nurse Home Visiting Program	*David Olds, Robert Tatelbaum, and Charles Henderson, Jr.*	Not Applicable	54, 55, 56
***A Health Care Program for First-Time Adolescent Mothers and their Infants**	*Ann L. O'Sullivan*	9	57
***Queen's Hospital Center's Teenage Program**	*Jill M. Rabin and Vicki Seltzer*	10	60
A School-Based Intervention Program for Adolescent Mothers	*Victoria Seitz and Nancy Apfel*	Not Applicable	67

The 15 Promising STD/HIV/AIDS Prevention Programs

Program Name	Program Developer(s)	Chapter Describing Program	References
Adolescents Living Safely: AIDS Awareness, Attitudes & Actions	*Mary Jane Rotheram-Borus, Sutherland Miller, Cheryl Koopman, Claire Haignere, and Calvin Selfridg*	11	64, 65
Adolescents Living Safely: AIDS Awareness, Attitudes & Actions for Gay, Lesbian and Bisexual Adolescents	*Sutherland Miller, Joyce Hunter, and Mary Jane Rotheram-Borus*	12	66
AIDS Prevention and Health Promotion Among Women	*Stevan E. Hobfoll, Anita P. Jackson, Justin Lavin, Paula J. Britton, and James B. Shepherd*	13	25, 42
AIDS Prevention for Adolescents in School	*Heather J. Walter and Roger D. Vaughan*	14	78
ARREST: AIDS Risk Reduction Education and Skills Training Program	*Michele D. Kipke*	15	36
AIDS Risk Reduction for College Students	*Diane L. Kimble Willcutts, Jeffrey D. Fisher, William A. Fisher, and Stephen J. Misovich*	16	21
***A Clinic-Based AIDS Education Program for Female Adolescents**	*Vaughn I. Rickert, Anita Gottlieb, and M. Susan Jayose*	17	62, 63
Get Real about AIDS	*Comprehensive Health Education Foundation*	18	46
Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth	*New England Research Institutes and Hispanic Office of Planning & Evaluation*	19	68

Riker's Health Advocacy Program (RHAP)	*Stephen Magura, Janet L. Shapiro, and Sung-Yeon Kang*	20	45
Safer Sex Efficacy Workshop	*Karen Basen-Engquist*	21	6
Youth AIDS Prevention Project (YAPP)	*Susan R. Levy, Brain R. Flay, D. Phil and Arden S. Handler*	22	43, 44
Youth and AIDS Project's HIV Prevention Program	*Gary Remafedi*	23	61

LOOKING TO THE FUTURE

While the effects of these programs have, for the most part, been modest and demonstrated on but a single site with but a single group of teens, they have in all likelihood been at least a partial contributor to the country's focus on the problem of teen pregnancy, a focus that has led to the sixth straight year of decline in the teen birth rate. The programs are diverse in terms of their population of interest, their approach, and their components. Viewing them as a group has led to some notion of "what works" in preventing teen pregnancy and teen STI/HIV/AIDS. Prevention program developers would be well advised to include these components of effective programs in future prevention programs. Where might the field go from here? What lessons have we learned about developing pregnancy prevention approaches, programs, and initiatives?

1. *An inclusive, eclectic approach is best.* There is disagreement in the country about whether teen pregnancy prevention programs should focus on abstinence and/or contraception. The most effective programs convey a simple, two-part message: "(1) Abstinence is the gold standard behavior for teens in middle and high school because, among other reasons, it is the only way to be 100% sure you will not get pregnant or cause a pregnancy to happen. (2) If, however, you do choose to have sex while still an unmarried teenager, you must use contraception and protect yourself from a sexually transmitted infection every time you have intercourse, including the very first time." Programs or communities that are uncomfortable with either part of this two-part message can choose to deliver only one of the parts. But they will not be transmitting the most powerful message that is available.
2. *Continue strengthening programs by building on what we know regarding "what works."* Once a general approach is chosen, whether it be abstinence, sex education, contraception provision, youth development, a community-wide initiative, or a combination of these approaches, the focus in pregnancy prevention programming should shift to delivery of the strongest possible program, given existing resource and time constraints. To this end, the following research-based principles may be helpful:
    - *Base your intervention program on a rigorous "program model."* A logical connection should exist between the components, length, and intensity (dosage) of each prevention program, media campaign, or community-wide initiative and both: (1) the short-term

outcomes and long-term impacts the intervention hopes to achieve, and (2) the age, culture, and level of risk of the target population.

- *Include characteristics, approaches, and components of effective programs*. A dozen or so such characteristics, approaches, and components have been discerned by evaluation research and discussed in this paper [8, 38].
- *Start with programs that have been shown to work*. Thirty such starting points have been described in this paper, 23 of which are available in already-packaged format from PASHA, the Program Archive on Sexuality, Health & Adolescence [8].
- *Replicate, adapt, and re-evaluate promising programs in other sites*. PASHA is a research-based resource for practitioners. However, most of the programs in PASHA have been shown to work in only one site, with but a single group of teens. The field would be moved forward by continued traversing of the research-to-practice feedback loop. If programs shown to be promising by evaluation research, such as those selected by the PASHA Scientist Expert Panel, are delivered in other settings with new groups of teens, and if these replications or adaptations are then re-evaluated themselves, we will start to have a more definitive notion of "What works? For whom? Under what circumstances?"

3. *Continue strengthening evaluations*. The move toward definitive answers to "What works?" needs not only stronger programs but stronger evaluations as well.
    - *Use state-of-the-art evaluation methodology*. Evaluation methodology has progressed in recent years. A research design employing random assignment to treatment and control groups when possible (or quasi-experimental designs when not), with sufficient sample sizes and power to detect hypothesized effects, and with rigorous efforts for combating attrition in both the treatment and control groups should be the standard for evaluations seeking to answer the question "What works?". When such standards cannot be met, a process evaluation measuring the extent to which the program has delivered the services or intervention as planned can still be very helpful. But a process evaluation cannot speak to the effectiveness of one's effort in changing sexual or contraceptive behavior among participating teens. Thus it cannot help answer the question of how we can prevent teen pregnancy.
    - *Advance the state-of-the-art for evaluating the effectiveness of media campaigns and community-wide initiatives*. As this paper has pointed out, teen pregnancy is a complex problem that is rooted in an elaborate constellation of societal, familial, and individual antecedents. Effects of individual programs have been real, but modest. Attempts are being made to develop and deliver larger-scale interventions, such as media campaigns and community-wide initiatives. The state-of-the-art for evaluating the effect of these broad efforts on individual behavior and community pregnancy or birth rates is still in a primitive state. Methodological advances are in order.
    - *Lengthen the time frame for the evaluation*, especially for programs aimed at middle school children. There is consensus in the field that the standard for evaluating program effectiveness should be sexual, contraceptive, and STI-protective behavior, and not knowledge, attitudes, or intentions. After all, broad and accurate knowledge, good attitudes, and good intentions are not what prevent pregnancies or sexually transmitted infections. When this standard (behavioral change) is applied to evaluations of pregnancy prevention programs aimed at middle school children, it will be difficult to document an effect unless the time frame for the evaluation is much longer than the six- to 12-months post-program follow-up used by most evaluation research studies. This is so because less than a quarter of the general population have intercourse before the age of 15, the age

> at which students move from middle school to high school [49]. This means that six to 12 months post-program, only a very small minority of "hard core," harder-to-reach middle school students will have had sex. It would take an unusually strong intervention to document any behavioral effects. Evaluation of middle school programs should either relax the outcome criteria to include changes in sexual values, attitudes, and intentions (as proxies for future behavior) or plan for a longer evaluation time frame (waiting until the teens reach high school before collecting the last round of follow-up data). Of course in a high-risk middle school population this concern would not be as serious, as larger percentages of students in both treatment and control groups would be expected to have made, or be in the process of making, the transition to non-virginity.

Prevention programs do tell part of the story of how teen STI, pregnancy, and childbearing rates can be lowered. But they tell only *part* of the story. In the end, more rapid progress will likely be made if: (1) national consensus could be reached, or at least common ground increased, on the nature of the problem and on acceptable solutions; and (2) all programs were sensitive to the larger context and culture in which their teens exist, so that the problem is always seen through the eyes of the teenagers themselves whom these programs seek to serve.

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1

Human Sexuality—Values & Choices:

A Values-Based Curriculum for 7th and 8th Grades

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Program Abstract

Title

Human Sexuality—Values & Choices: A Values-Based Curriculum for 7th and 8th Grades

Summary

Developed for use in 7th and 8th grade classrooms, this program aims to reduce teenage pregnancy by promoting seven core values that support sexual abstinence and healthy social relationships. The curriculum—including 15 student lessons and 3 adult-only sessions—is distinguished by: 1) an emphasis on parent-child communication; and 2) the use of a standardized, video-assisted format. Participants gain mastery through role-plays, group discussions, and behavioral skill exercises. Following a field test in nine schools, program participants showed a greater understanding of the risks associated with early sexual involvement, and they expressed increased support for postponing sexual activity, as compared to a control group of their peers.

Focus

☑ Primary pregnancy prevention ☐ Secondary pregnancy prevention ☐ STD/HIV/AIDS prevention

Original Site

☑ School-based ☐ Community-based ☐ Clinic-based

Suitable for Use In

This program is suitable for use in schools and any other community organization that provides education or services to seventh and eighth graders.

Approach

☑ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☐ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☐ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age	56% age 12, 33% age 13, 7% age 14.
Gender	48% Male.
Race/ Ethnicity	62% White, 19% African-American, 10% Hispanic, 9% Other (includes Asian and Native American).

Program Components

- ☑ Adult Involvement
- ☐ Case Management
- ☑ Group Discussion
- ☑ Lectures
- ☐ Peer Counseling/Instruction
- ☐ Public Service Announcements
- ☑ Role Play
- ☑ Video
- ☐ Other ________

Program Length

The 15 student lessons are designed to run 45-50 minutes each. The 3 parent sessions should each last about 2 hours. The sequencing of the sessions is flexible.

Staffing Requirements/ Training

There are no special requirements. An accompanying *Teacher's Manual* provides detailed instruction to help classroom teachers implement the curriculum.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

HealthStart and Search Institute initiated *Human Sexuality—Values & Choices: A Values-Based Curriculum for 7th and 8th Grades* (hereafter referred to as *Values & Choices*) in 1983, as a 15-session curriculum for 7th and 8th grade students that is accompanied by a three-session mini-course for parents. The school-based program aims to reduce teenage pregnancy by teaching not only "the facts" of human reproduction but also a core set of values that support sexual abstinence and healthy social relationships. Set in the context of a comprehensive sexuality education program, *Values & Choices* is distinguished by: a) an emphasis on parental involvement across the curriculum; and b) the use of a standardized, video-assisted format. Moreover, because the program is targeted toward younger adolescents, it measures changes in attitudes, knowledge and intentions as indicators of future sexual behavior.

The intervention was developed under Title XX—Adolescent Family Life Demonstration Projects—a 1983 Congressional amendment to the Public Health Service Act. As a national demonstration project, *Values & Choices* was sponsored by the Office of Adolescent Pregnancy Programs, US Department of Health and Human Services, with additional private matching funds. Following the curriculum development process, researchers conducted an experimental field test and evaluation study in a diverse set of schools across five sites: Detroit, MI; Minneapolis and Grand Rapids, MN; Denver, CO; and the San Francisco, CA Bay area. It has since been implemented in more than 2,000 schools in the US and Canada.

Seven Core Values

The program presents the following seven values as the basis for understanding human relationships in general, and sexuality in particular:

- equality
- honesty
- respect
- responsibility
- promise-keeping
- self-control
- social justice

The decision to emphasize values stems from research in social psychology demonstrating links between an individual's values and behavior. For example, Rokeach (1973) found that college students who had been induced to change the relative importance they attached to particular values, including freedom and equality, later showed an increase in such behaviors as donating money to charitable organizations and enrolling in ethnic studies courses.

Theoretical Framework

Values & Choices applies Fishbein's Behavioral Intention Model, which argues that an action, such as the decision to have sex, results from an individual's intention to act. Such behavioral intentions, in turn, consist of four components:

1) **beliefs** about the outcomes of actions;
2) **evaluations** of those outcomes;
3) **perceptions** of others' opinions about the act; and
4) **motivation** to comply with others' opinions.

For example, in preliminary research for the program, 7th and 8th grade students expressed nine **beliefs** concerning the outcomes of sexual intercourse:

- getting pregnant (or getting someone pregnant)
- getting a venereal disease
- showing people I love them
- pleasing my boyfriend/girlfriend
- being popular
- holding on to a boyfriend/girlfriend
- feeling worthwhile, feeling important
- feeling grown-up
- finding out what sex is like

The theory recognizes that students' beliefs about intercourse may not be rational or logical; nevertheless these beliefs, in conjunction with evaluations, perceptions and motivations, determine whether one will act. In addition, incorporating research by Gorsuch, the program developers added values as a final component of their model.

In their field test of *Values & Choices,* researchers measured the relative importance of, and change over time in, students' beliefs, evaluations, motivations, perceptions and values regarding sexual decision-making, as well as in students' overall intention to engage in sexual activity. The specific indicators and analyses used to assess the program's effectiveness are described in greater detail in the evaluation section of this guide.

The parental component of the program is tied to research associating positive parent-child communication on sexuality with both a delay in the onset of sexual intercourse and, among teens who do engage in intercourse, greater probability of effective contraception use (Chilman, 1980). However, more recent studies in this area have produced ambiguous findings (Hofferth & Hayes, 1987). The program developers further reasoned that parental involvement could help reduce community opposition to sexuality education while enabling adults to reach informed decisions about their children's participation. In addition, it was hoped that the parental sessions would foster mutual support and encouragement among participants for discussing sexuality at home.

The program developers used videotape because of its convenience, perceived effectiveness and increasing popularity. Further, they believed that interviews with a racially, ethnically and socioeconomically diverse sample of youth, as was feasible with pre-recorded tape, would carry greater significance for students. Finally, the standardized format could alleviate parents' concerns about the presentation of sensitive material to their children.

Intervention Goals

Values & Choices aims to promote sexual abstinence among adolescents, while addressing the full range of issues facing this age group. In addition, because many youngsters form their values during adolescence, the program encourages students to incorporate values into sexual decision making and all social relationships.

Program Objectives

The overall goal of the curriculum is to delay initial sexual involvement among 7th and 8th grade students. Three objectives support this goal:

1) To decrease students' intention to engage in intercourse "while I am a teenager;"
2) To strengthen values supporting sexual abstinence during adolescence; and
3) To increase parent-child communication regarding sexuality.

Hypothesized Outcomes

For students participating in the *Values & Choices* program, the following outcomes are predicted:

Hypothesis 1: Effects on students

- increased support for sexual restraint during adolescence
- decreased support for the idea that males have a stronger, less controllable sex drive

- increased knowledge concerning human reproduction and the effects of adolescent pregnancy
- increased frequency of conversations with parents concerning sexuality
- decreased support for sexual coercion
- increased support for values that will inhibit premature sexual involvement
- decreased behavioral intention to engage in intercourse
- no change in overall attitude toward sexuality

Hypothesis 2: Effects of parent involvement

It is expected that the above effects will be stronger for those students whose parents also participate in the program.

Hypothesis 3: Effects of other important variables

In their field test of the curriculum, researchers measured the influence of a number of background variables on program outcomes. Lacking sufficient information from previous investigations to predict the effects of these variables, the researchers simply hypothesized that the outcomes described above would be significant across different categories regardless of students' gender, race, virginity status, or educational aspirations. Similarly, they predicted that the income and educational level of participants' parents would not affect the overall pattern of results.

Program Schedule

Program Outline

Each of the fifteen student lessons is tied to one or more of the program's seven core values. Key concepts are defined and reinforced through in-class and at-home activities. Class sessions are designed to last approximately 45 to 50 minutes.

Listed below are the titles, goals and values for the student sessions. All lessons, including both parent and student sessions, are described in greater detail in the *Teacher's Manual* for the program.

Student Lessons

LESSON 1: **Starting Out!**

Goals: To introduce the program and establish a friendly atmosphere and basic ground rules for the course.

Values emphasized: Respect (primarily self-respect)

LESSON 2: What's Really Important?

Goals: 1) To increase students' understanding of the concept of values and the role of values in decision-making. 2) To increase students' familiarity with the basic values promoted by this curriculum.

Values emphasized: All

LESSON 3: Changes

Goal: To promote an understanding of the physical changes in puberty and their relationships to sexuality.

Values emphasized: Respect, Responsibility

LESSON 4: More Changes

Goal: To promote an understanding of emotional changes in adolescence, especially sexual attraction, and to promote positive ways of dealing with emotions.

Values emphasized: Responsibility, Self-Control

LESSON 5: Equal Though Different

Goal: To promote equality and social justice for human beings, regardless of gender.

Values emphasized: Equality, Social Justice, Respect

LESSON 6: Making Choices

Goal: To help adolescents understand that choices are involved in most situations and that, in making choices, it helps to think about basic human values and possible consequences of choices.

Values emphasized: Honesty, Self-Control, Responsibility, Promise-Keeping

LESSON 7: Going Out?

Goal: To explore various aspects of dating and to develop guidelines for acting in ways that will promote healthy development.

Values emphasized: Honesty, Self-Control, Equality, Responsibility, Respect

LESSON 8: Saying No

Goal: To help teens recognize sexual pressure and to present reasons and ways to say no to sexual pressure.

Values emphasized: Self-Control, Respect, Promise-Keeping, Equality, Honesty

LESSON 9: Pregnancy and Birth

Goal: To promote an understanding of fetal growth and development, maternal changes, the process of labor and birth and the influence of parents' health on the baby's well-being.

Values emphasized: Responsibility, Self-Control, Equality

LESSON 10: Planning

Goals: 1) To promote abstinence as the best method of avoiding pregnancy for teens. 2) To provide information on other available family planning methods.

Values emphasized: Responsibility, Respect, Equality

LESSON 11: Teenage Pregnancy - The Reality

Goal: To provide an understanding of the consequences of teenage pregnancy and the choices involved.

Values emphasized: Responsibility, Respect, Equality

LESSON 12: Teenage Pregnancy - The Choices

Goal: To provide an understanding of the consequences of teenage pregnancy and the choices involved.

Values emphasized: Responsibility, Respect, Equality

LESSON 13: Taking Chances

Goal: To promote awareness of sexually transmitted disease as a possible consequence of sexual activity, along with knowledge of treatment and prevention.

Values emphasized: Honesty, Responsibility, Self-Control, Social Justice

LESSON 14: The Power of Touch

Goal: To promote an understanding of the difference between positive and abusive touch.

Values emphasized: Respect, Responsibility, Social Justice, Self-Control

LESSON 15: Moving On!

Goal: To apply the values and content of the course to practical situations faced by teens.

Values emphasized: All

Program Materials: Replicating or Adapting *Human Sexuality—Values & Choices*

Instructional Materials

The *Human Sexuality—Values & Choices* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of this book. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Teacher's Manual. The introduction to this manual provides teachers with a general overview of the program's methods and objectives. In addition, the manual contains a comprehensive outline and script for the three parent and fifteen student sessions, as well as the lesson goals, and values, concepts, attitudes and behaviors the instructor will explain and promote. A checklist reminds the teacher what materials will be needed (e.g., VCR, large newsprint pad) for each session. Teacher reference pages provide additional pertinent information for selected lessons, and the home activity pages, describing the homework assignment, are ready for photocopying.

Videotape. Twelve of the *Values & Choices* lessons incorporate brief (5-10 minute) video clips, which are arranged sequentially on the program tape. Several segments show teens discussing personal experiences of pubertal development, sexual attraction and interpersonal relationships; adolescents from a wide range of backgrounds are presented. In other segments, actors face difficult situations (e.g., one dating partner pressuring the other to have sex); when the scene ends, students are invited to discuss what they would do.

A Guide for Parents of Young Adolescents. This should be distributed at the first parent session (one per household). This book encourages parents to talk with their children about sexuality and to incorporate values into their conversations. For each of the fifteen *Values & Choices* lessons, the book explains "what teens think" and suggests "what parents can do" to help their children make healthy decisions. The guide is available in English and Spanish.

Activity Masters. Included in this packet are masters for all of the homework and class activities; they can be photocopied or made into transparencies.

Additional Resources

The materials described below are also included in the PASHA program package. They may be used to enhance and supplement your core curriculum.

My Values, My Choices: A Student's Thoughtbook. Teachers may want to supplement their *Values & Choices* program with some of the 27 reflective exercises included in this workbook. Designed to reinforce class lessons, the exercises prompt teens to think and write about, for example, qualities they like in themselves and in family members, the significance of particular values, reasons for delaying sexual intercourse, and sources of pressure in their lives.

My Values, My Choices: Teacher's Guide. This handbook explains the rationale for the exercises included in the *Student's Thoughtbook*. Suggestions for expanding the exercises into class activities and discussions are also provided.

Values cards. These pocket sized plastic cards list the seven basic values emphasized in *Values & Choices*, along with key questions to consider in social settings (e.g., "Is this a risky situation?" "Am I being pressured?" "What other choices do I have?"). Your package includes 35 cards.

Values & Choices poster. This 7 1/2"x 11" poster lists and defines the seven core values.

Yes You Can! A Guide for Sexuality Education that Affirms Abstinence among Young Adolescents (hereafter referred to as *Yes You Can!*). Teachers, administrators and program leaders will find the section, "A facilitator's guide to sexuality education" of particular value in preparing instructors to implement the curriculum. A brief summary of normal sexual development and a list of sexuality education resources are included. A separate section outlines strategies for gaining authorization and support for the program and for engaging parents in the process. Sample parent consent forms and publicity flyers are also provided.

Breaking the Silence. This 30-minute audiotape presents strategies to guide parents in discussing sexuality with their children.

Additional Supplies Needed to Implement the Program

The PASHA program package provides all of the curricular materials needed to implement *Values & Choices*. However, additional equipment is required for many of the sessions, including a TV and VCR, photocopier, cardboard box for students' anonymous questions, and a chalkboard or flip chart and markers for use during group discussions. An overhead projector and blank transparencies are optional. Additionally, students are asked in one of the homework activities to care for "babies," which may be simulated by raw or hard-boiled eggs, seedlings or paper cups.

How to Implement the Program

Prior to the first lesson, instructors should read all program materials and view the accompanying videotape. Included in *Yes You Can!* are current statistics on teen pregnancy, summaries of male and female sexual development and additional resources to help prepare instructors to address questions from students and parents, as well as community concerns about the appropriateness of a sexuality education program. Issues concerning effective communication, personal disclosure and the use of street vs. slang language are discussed in the guide for effective teaching (also in *Yes You Can!).*

In the field test of the program, letters carrying the principal's endorsement (and explaining the purpose of the curriculum) were sent home to parents. Sample letters and consent forms can also be reviewed in *Yes You Can!*

In addition, instructors will want to familiarize themselves with procedures for responding to three special issues likely to arise during the program: 1) confidentiality and mandated reporting of abuse, should students share personal experiences of such incidents; 2) laws and policies related to STDs, including testing, treatment and reporting; and 3) student requests for counseling, family planning and pregnancy testing, as well as parental notification laws regarding such services.

It is recommended that the first parent session take place before the student lessons begin, and teachers may wish to invite their principals to briefly welcome participants. Suggestions for designing, scheduling and facilitating parent sessions are included in the *Teacher's Manual* and *Yes You Can!*

Briefly reviewing lesson outlines, scripts and checklists of activities and materials before the start of each lesson will ensure that classes flow smoothly. All of these items are included in the *Teacher's Manual.*

Evaluating the Program

The Original Evaluation

Design

The program's effectiveness was originally investigated in a field study conducted in nine schools across the country. The study compared the sexual attitudes of 7th and 8th grade students who completed the *Values & Choices* curriculum to those of a control group of teens selected from the same grades and schools. Data were collected with a self-report questionnaire administered to both groups of youth at three points in time:

- Time 1: before the start of *Values & Choices*;
- Time 2: immediately following the lessons; and
- Time 3: three to four months following completion of the program.

In addition, parents participating in the adult sessions were given brief questionnaires at Time 1 and Time 2.

The nine schools serving as study sites were located in five areas: Detroit, MI; Minneapolis and Grand Rapids, MN; Denver, CO; and the San Francisco, CA Bay area. The full sample included 657 students from rural, urban and suburban communities, collectively representing a range of ethnic, racial and socioeconomic characteristics.

Evaluation Questions

Three empirical questions guided the field study:

1) What effects does program participation have on 7th and 8th grade students? In particular, how effective is the course in:

   —decreasing teenagers' intention to engage in intercourse "while I am a teenager?"

   —strengthening values supporting sexual restraint in adolescence?

   —increasing parent-child communication concerning sexuality?

2) What impact does parental participation have on student outcomes?

3) Do the effects of program participation vary with a student's gender, race, virginity status, family income, parental education and personal educational aspirations?

All student data were gathered with a 100-item questionnaire developed and pilot tested for use with 7th and 8th grade populations. To assess students' attitudes toward sexual restraint, for example, respondents were asked whether they agreed or disagreed (on a 5-point scale) with the following items: "Having sex is something that only adults should do" and "Even if I'm physically mature, that doesn't mean I'm ready to have sex." Individual items were combined into the following composite measures: Sexual Restraint Scale; Beliefs Concerning the Male Sex Drive; Sexual Knowledge Test; Parental Conversations Scale; Sexual Coercion Scale; Behavioral Intention to Engage in Intercourse; Perceptions and Motivations; Attitudes toward Sexuality; and Values.

Parent data were gathered in a separate, shorter questionnaire assessing respondents' attitudes toward teen sexual involvement; frequency and scope of conversations with child concerning sex; and personal feelings about such conversations. Background data on the home environment, parents' age, marital status and educational level were also collected. With the exception of the parental education variable, these measures were primarily used to address evaluation question #2, as listed above.

Data Collection Procedures

Prior to the start of the *Values & Choices* program, letters carrying the principal's endorsement were sent to the parents of all students enrolled in classes participating in the intervention. The research team explained the course's purpose and methods, and requested consent for the child's participation. A pre-addressed, stamped envelope addressed to the school was also enclosed.

Following a "school as its own control" strategy, a comparison group of students was constructed within each participating school. Parents of students enrolled in control classes received a separate letter and information packet. These materials highlighted both the importance of control groups to evaluation research and the potential for their child's later participation in the *Values & Choices* program.

Regional researchers administered the Time 1 questionnaire, in class and before the start of the lessons, to all students whose parents consented. Teens were assured that their questionnaire responses would be anonymous (e.g., school personnel and parents would not have access to them), and the phrase "Confidential—to be opened by Search Institute personnel only" was printed on the envelope containing each test booklet. After answering procedural questions, researchers asked students to respond the way they "really felt" to each of the test items. The remainder of the survey was self-administered.

Similar procedures were followed for the Time 2 and Time 3 administrations, as well as for the parent questionnaires.

Research Sample

Across field study sites, usable data from all three survey periods were gathered for 452 students in the treatment group and 205 control group students. With the exception of gender, for which the experimental group had a greater proportion of males (48% vs. 43%), few demographic differences were observed between the groups. Overall, 62% of respondents described themselves as white, 19% as black, 8% as Hispanic, 3% Asian or American Indian, and 4% as "other." The majority of students, approximately 70%, reported that they lived in two-parent families. More than half of the fathers and 40% of the mothers had completed college.

On measures of sexual behavior, 57% of students reported dating in the past year, and 20% described themselves as non-virgins.

Evaluation Results

Analysis of the survey data revealed that the short-term intervention produced a number of immediate attitudinal changes in teens; long-term change, on the other hand, was far more difficult to sustain.

Effects on Student Attitudes

At Time 2, following completion of the *Values & Choices* lessons, 7th and 8th grade participants showed:

- increased support for sexual restraint;
- decreased belief that boys have stronger or more uncontrollable sex drives than girls;
- increased knowledge of human reproduction;
- increased belief that having intercourse can result in pregnancy;
- increased belief that intercourse can result in STDs;
- increased frequency of conversations concerning sexuality;
- decreased intention to engage in intercourse while a teenager; and
- decreased support for the use of coercion in sexual relations.

The significance level for all effects was at least $p<.05$.

In the long term, as measured three to four months following participation in the program, *Values & Choices* students were still:

- less likely to believe that boys had stronger or more uncontrollable sex drives than girls;
- more likely to believe that they could get an STD if they had teen sex; and
- more likely to believe that they could get pregnant if they had sex as a teenager.

Again, all effects were significant at least at the $p<.05$ level.

To illustrate one of the changes: before *Values & Choices*, 33% of treatment group students believed it would be against their values to have sex as a teenager. Immediately following the program, 45% of treatment group students felt this way. Although the figure declined to 38% in the delayed post-test period, the proportion of students endorsing sexual restraint remained above the pre-test level.

In evaluating their empirical model, the researchers compared students' behavioral intention to engage in sex across the three survey periods. Overall, on a 100-point intention scale, the control group showed no change over time, measuring 49.7 across all test periods. The treatment group, in contrast, showed a small but significant decline between Time 1 and Time 2 (from 50.7 to 46.5), followed by a small, significant increase to 48.4 at Time 3. Focusing on individual components of the model, the researchers found that values were most influential in determining whether a teenager would be likely to engage in sex.

Effects of Parental Participation

Only one significant effect was found for parental participation in the *Values & Choices* program. On measures of sexual knowledge, students whose parents attended the adult sessions showed a smaller decline in their scores over time, relative to their peers with non-participating parents. Yet the researchers' hypothesis was refuted, for parental participation had no effect on student attitudes toward sexual intercourse.

Effects of Other Important Variables

Two of the background variables—gender and virginity status—showed consistent effects on the outcome measures. Compared to boys and non-virgins, girls' and virgins' attitudes were less supportive of sexual activity during adolescence. Race showed inconsistent effects, and the other variables measured—income, parental education and educational aspirations—appeared insignificant.

Summary

Overall, the researchers concluded that *Values & Choices* had a positive, short-term effect on the sexual attitudes and values of 7th and 8th grade students. As predicted, students completing the 15-session curriculum showed an increased understanding of human reproduction and the risks associated with early sexual activity, relative to their peers in the control group; they were also more likely to discuss such matters with their parents. In addition, these teens showed less support for the idea that boys' sexual drive is uncontrollable or that sexual coercion is acceptable. And they showed greater sexual restraint, expressing less intention to engage in intercourse as a teenager. Such effects were strongest for females and virgins.

However, in the follow-up survey taken three to four months after the program, only three effects remained significant. Compared with their control group peers, *Values & Choices* participants were still more likely to recognize the risks associated with sexual activity (e.g., STDs, pregnancy), and less likely to believe that boys' sex drives were uncontrollable. All other program effects had faded.

The researchers emphasized that their data fit the pattern typical of attitudinal change research, with significant short term gains that weaken over time. Once the program ended, the researchers reasoned, students would have found little support in the media or their peer culture for the kinds of lessons promoted in the *Values & Choices* curriculum, notably sexual restraint in adolescence. Furthermore, in interpreting the small differences between many of the treatment and control group scores, the researchers suggested both maturation and spillover effects. First, some of the measures included in the study might be expected to change over time; for example, teenage students would become more knowledgeable about sex as they sought out new information. Second, with both groups of students attending the same schools, the attitudes and values of the control group might spill over to students in the treatment condition. The researchers noted that both processes would yield conservative measures of the program's effectiveness.

Evaluation Materials for *Human Sexuality—Values & Choices*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: questionnaires used in the original evaluation, *A Minimum Data Set* for *Evaluating Programs Aimed at Preventing Adolescent Pregnancy*, and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

Student Questionnaire. This 111-item survey includes questions on family background, sexual values, attitudes, knowledge and behavior, and patterns of communication with adults. The same instrument is used at all three assessment periods.

Parent Questionnaire. This brief survey, completed by parents who participate in the adults-only sessions, is administered at the Time 1 and Time 2 assessments. Questions measure

attitudes toward teen sexual involvement and communication with children concerning sexuality.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Values & Choices*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

2

Project TAKING CHARGE

An Adolescent Pregnancy Prevention Program

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Program Abstract

Title

Project TAKING CHARGE

Summary

This program, developed for junior high school home economics classrooms, integrates family life education with lessons on vocational exploration, interpersonal relationships, decision making and goal setting. A key premise of the intervention is that vocational planning can lead to attractive alternatives to early sexual involvement and parenthood. In a special job-shadowing exercise, for example, students observe and interview individuals working in a variety of occupations. In addition, *Project TAKING CHARGE* emphasizes that values such as equality, self-control, respect for others, responsibility, honesty, promise-keeping, self-esteem, dependability, trustworthiness, justice and fairness lead to good citizenship, fulfilling relationships, and sound personal ethics. Along with values, *Project TAKING CHARGE* promotes abstinence as the correct choice for adolescents; no material on contraception is included. The curriculum is comprised of five instructional units that are divided into 27 class lessons. There are also three parent-youth sessions during which adults are encouraged to communicate their own sexual standards and assist teens in defining and attaining occupational goals.

A field study was conducted with 136 youths from three low-income communities with elevated rates of teen pregnancy. Six months following the program, participants showed significant gains in knowledge of sexual development, STDs, and the risks of adolescent pregnancy, relative to a comparison group of students. There was also some evidence, falling just short of significance, that participation was associated with a delay in the initiation of sexual intercourse.

Focus

☑ Primary pregnancy prevention
☐ Secondary pregnancy prevention
☐ STD/HIV/AIDS prevention

Original Site

☑ School-based
☐ Community-based
☐ Clinic-based

Suitable for Use In

Although it was originally implemented in school classrooms, the curriculum can also be presented by health educators in community-based organizations.

Approach

- ☑ Abstinence
- ☑ Behavioral Skills Development
- ☐ Community Outreach
- ☐ Contraceptive Access
- ☐ Contraceptive Education
- ☑ Life Option Enhancement
- ☑ Self-Efficacy/Self-Esteem
- ☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age, Gender	The field study included 136 7th-grade students, evenly divided by gender; of this group, 60% were 12 years old and 34% were 13.
Race/ Ethnicity	63% White, 29% African-American, 4% Hispanic, 4% other

Program Components

- ☑ Adult Involvement
- ☐ Case Management
- ☑ Group Discussion
- ☑ Lectures
- ☐ Peer Counseling/Instruction
- ☐ Public Service Announcements
- ☑ Role Play
- ☑ Video
- ☐ Other __________

Program Length

The curriculum contains five instructional units with 27 class lessons. Scheduling is flexible—the full program might take between six and nine weeks to complete.

Staffing Requirements/ Training

Lessons are designed for family life educators to use in their 7th grade classrooms. The national office of *Project TAKING CHARGE* offers workshops and materials to help prepare instructors. For details call the national office at (703) 706-4600.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health &

Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

Based on the idea that vocational planning can lead teens to attractive alternatives to premature sexual activity and parenthood, *Project TAKING CHARGE* integrates sexuality and family life education with lessons on vocational development, interpersonal relationships, decision making and goal setting. Moreover, the program presents sexuality as a life-long process. The process involves knowledge acquisition and the development of attitudes, beliefs and values about identity, relationships and intimacy. Sexual maturation, human reproduction, interpersonal relationships, affection, intimacy, body image and gender roles are all part of one's sexuality.

To provide junior high school in home economics class students with a comprehensive understanding of sexuality, *Project TAKING CHARGE* includes discussion of anatomy, physiology, family, parenthood, sexually transmitted diseases and HIV/AIDS. Throughout the program, abstinence from premature sexual intercourse is promoted as the most responsible choice for young teenagers. In addition, lessons and group activities are designed to help participants: (1) recognize that their current decisions will impact their future lives; (2) understand the physical and emotional sides of puberty; and (3) enhance their ability to speak about sexuality, education and career development with their parents.

During the fall of 1989, a field study of the program was conducted with 136 low-income seventh-grade students and their parents in Delaware, Mississippi and Ohio. Funding was provided by the US Office of Adolescent Pregnancy Programs, Department of Health and Human Services.

Theoretical Framework

Project TAKING CHARGE is based on Robert J. Havighurst's concept of developmental tasks. These tasks, which arise at a particular stage of life, present a person with important psychological and social challenges. During adolescence, for example, youth must begin making decisions about (future) marriage and family life, as well as planning for a career. The resolution of such tasks brings a sense of well-being and confidence in meeting new challenges. Alternatively, failure to resolve tasks at one stage of development may lead to social disapproval, unhappiness, and difficulties in approaching future tasks.

Tasks Addressed in the Program

The *Project TAKING CHARGE* curriculum introduces teens to the following developmental tasks:

(1) learning to get along with friends of both sexes;

(2) accepting one's physical body and keeping it healthy;

(3) becoming more self-sufficient;

(4) making decisions about (future) marriage and family life;

(5) preparing for a job or career;

(6) acquiring a set of values to guide behavior (including self-respect or self-esteem); and

(7) becoming socially responsible.

As part of the sixth developmental task, "acquiring a set of values to guide behavior," the curriculum emphasizes the following values that are generally regarded as basic tenets of good citizenship, fulfilling relationships and sound personal ethics: equality, self-control, respect for others, responsibility, honesty, promise-keeping, self-respect or self-esteem, dependability, trustworthiness, justice and fairness.

Program Overview

Focusing on the values and developmental tasks described above, *Project TAKING CHARGE* aims to help young teens identify what they need to accomplish to mature successfully, make healthy behavioral choices, gain self-esteem and develop fulfilling relationships. Moreover, the program encourages youth to take an active part in their own development ("taking charge") while clarifying personal values and abstaining from sexual involvement. Parent-child communication concerning sexual values, standards and vocational planning is also promoted.

To help teens gain a deeper sense of the opportunities ahead, the curriculum encourages collaboration among businesses, parents and schools. In a special job shadowing exercise, for example, students observe and interview individuals working in a variety of occupations.

Program Objectives

The objectives of *Project TAKING CHARGE* have been adapted from the goals and objectives of the Office of Adolescent Pregnancy Programs, Department of Health and Human Services, under the 1981 Adolescent Family Life Act (Title XX of the Public Health Services Act). Accordingly, the program aims to help youth:

(1) identify values: their sources and their impact on behavior;

(2) relate moral dimensions of values in goal setting to decision making;

(3) recognize the influence of gender roles, gender stereotypes, gender inequity and gender discrimination;

(4) analyze the choices and challenges facing early adolescents;

(5) understand adolescent development and human reproduction;

(6) develop a more positive attitude about each individual's worth and about one's ability to "take charge" of one's own life;

(7) recognize the importance of relationships with family members and friends;

(8) develop and practice skills for communicating about sexual facts, personal values and vocational planning strategies;

(9) develop and practice conflict resolution skills;

(10) identify high-risk behaviors that can prevent one from reaching life goals;

(11) understand the importance of abstinence from high-risk behaviors, including sexual intercourse and the use of alcohol and other drugs;

(12) practice "saying no" to high-risk behaviors;

(13) gain knowledge of various occupational requirements (education and training), job-seeking strategies and community vocational resources;

(14) identify personal interests; and

(15) review community resources available to provide information about various occupations, occupational requirements (education and training) and job-seeking strategies.

Program Schedule

The *Project TAKING CHARGE* curriculum includes three main sections: Who Am I?, Where Am I Going? and How Do I Get There?

The curriculum is further divided into five units (with 27 lessons) and three parent-youth sessions. Each lesson can be completed in approximately 45 minutes, and individual activities may take about 15 to 30 minutes. The curriculum is flexible enough to be completed in a six- to nine-week term.

Detailed outlines—along with tips and guidelines—for leading each lesson are provided in the *Project TAKING CHARGE Curriculum Manual*. Each outline includes objectives, a plan for leading both required and optional activities, the suggested time for completing them and the materials that will be needed. A brief overview of the program units appears below.

Unit 1: Who Am I? Making Healthy Choices

Four lessons are included in this unit—

- 1.1 Setting the Stage for Taking Charge of My Life
- 1.2 What's Really Important to Me?
- 1.3 Gender Roles and Stereotypes: Understanding My Choices
- 1.4 Diversity: Expanding Horizons

This unit introduces students to the idea that healthy choices should be based on values, sound decision-making skills and positive goal setting. After discussing the goals and expectations of the program, teens are invited to "take charge" of their development and future at an exciting and important stage of their lives.

During the second half of the unit, students prepare a "Values Chart." They also investigate gender roles and stereotypes by videotaping 15 minutes of children's television, including commercials. The final lesson explores diversity as a way to expand one's horizons.

Unit 2: Where Am I Going? Taking Charge of My Life

Seven lessons are included in this unit—

- 2.1 Plan for the Future: A Time to Dream
- 2.2 Changes and Challenges
- 2.3 Human Sexuality
- 2.4 Human Reproduction
- 2.5 Dealing with Things We Can and Cannot Change
- 2.6 Setting Goals
- 2.7 Making Decisions

The two goals of this unit are to help students understand the experiences and challenges of early adolescence, including human reproductive development and to begin to "take charge" of their future. In a class activity, students videotape a short segment of a current TV program and interpret the media's portrayal of teens. Next, the physical and emotional aspects of puberty are explored, and students sort the myths from the facts about this stage of life. The last few lessons in the unit are devoted to setting goals and making decisions. These tasks are personalized in an exercise that has students develop individual plans for realizing a goal they have set for their future.

Unit 3: How Do I Get There? Making the Most of Relationships

Six lessons are included in this unit—

- 3.1 A Closer Look at Relationships
- 3.2 Understanding Different Perspectives
- 3.3 Future Dating Relationships
- 3.4 The Basics of Communication
- 3.5 Practicing Communication Techniques
- 3.6 Sexual Abuse: Your Body is Your Own

This unit covers family relationships, future dating relationships and vocational planning. Students learn how families and friends serve as support systems and provide assistance with decision making and developmental tasks. To help students achieve fulfilling relationships, both within and outside the family, successful communication techniques are explained and practiced. One of the optional activities has the class videotape several brief interactions between family members on TV programs. In another activity students interview several teachers about parenting or caregiving. Understanding sexual abuse is the focus of the last lesson in the unit.

Unit 4: How Do I Get There? Taking Charge of My Choices and Behaviors

Five lessons are included in this unit—

- 4.1 Risky Business: Knowing When to Say No
- 4.2 Abstinence: Saying No
- 4.3 Alcohol, Other Drugs & You: Resisting Peer Pressure

- 4.4 Sex Can Be Dangerous: Sexually Transmitted Diseases (STDs) and Acquired Immune Deficiency Syndrome (AIDS)
- 4.5 Abstinence and the Costs of Early Parenthood

In this unit students learn about risky behaviors, reasons why adolescents engage in them and how to say "no." The benefits of abstinence are again affirmed in relation to avoiding STDs and early parenthood. One group activity, for example, uses popcorn as a symbol for illustrating peer pressure to use drugs. Within each group of five to eight students, one member is instructed not to eat any popcorn, while the others are told both to eat and to encourage others to do so. The class observes how group members pressure the "abstinent" student to conform. Other activities in this unit encourage students to contact community resources for information about STDs and research laws regarding teenage fatherhood and welfare eligibility.

Unit 5: How Do I Get There? Taking Charge of My Vocational Future

Five lessons are included in this unit—

5.1 Getting and Keeping a Job

5.2 Planning for Career Exploration

5.3 The Career Exploration Experience

5.4 Career Exploration: Sharing Experiences

5.5 Taking Charge: Where Do I Go from Here?

In the final unit of the program, students begin to take stock of themselves as future jobholders. They assess their inherent talents and abilities, and they investigate areas providing challenges for growth. The heart of this unit is an introduction to the workplace, and the curriculum includes three possible strategies. In Option 1, a job shadowing exercise, students visit community members at work and interview them about job requirements, including education and training, as well as their feelings about the position, potential for advancement, etc. A similar activity, Option 2, allows students to interview employees when visiting a work site. In Option 3, the class interviews a panel of employees who visit the class. To increase the number of positions to which students are exposed, each option allows for a full class period in which students discuss and compare what they have learned.

Parent-Youth Sessions

Three sessions are designed for students and their parents or guardians--

- 1. Understanding Adolescence
- 2. Communicating Parent-Teen Concerns
- 3. Career Planning: A Lifelong Process

These sessions aim to develop skills in communicating about sexual facts, personal values and vocational planning strategies. They also introduce participants to community agencies that provide information about various occupations, occupational requirements (education and training) and job-seeking strategies. The first parent-youth session, Understanding Adolescence, introduces the basic philosophy of *Project TAKING CHARGE* and invites parents to preview course materials. The second parent-youth session provides participants with opportunities to practice communicating feelings about sexuality, and the final session features a job/education fair. The fair is designed to build parental support for and involvement in realistic educational and career planning.

Supplemental Lesson

The *Curriculum Manual* includes a supplemental lesson on sexual hygiene. The lesson emphasizes teens' responsibility to care for their developing bodies, and it covers such topics as daily bathing, masturbation, menstruation, STD testing and regular medical care.

Program Materials: Replicating or Adapting *Project TAKING CHARGE*

The *Project TAKING CHARGE* package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of the book. The package includes the following materials needed to implement this program. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Curriculum Materials

Project TAKING CHARGE Curriculum Manual. This manual provides comprehensive outlines for all 27 program lessons, as well as the parent-youth sessions. At the front of the *Manual* instructors will find a suggested plan and schedule for organizing the program. Sample letters inviting local companies and community members to participate in the job shadowing exercise are also provided. Included in the appendix are: an outline for the supplemental lesson, related family life education resources, a glossary of key terms and duplicate copies of all worksheets and transparencies.

Project TAKING CHARGE Trainer's Manual. This manual is designed to assist program leaders in training family and health educators and others to implement the curriculum. It includes an overview of program goals and offers suggestions for organizing and promoting the training sessions. At the heart of the manual are detailed discussions of 20 training topics pertinent to the curriculum, including risk-taking behavior, cultural diversity, HIV/AIDS and other STDs, values, abstinence and self-esteem.

Sample worksheets, activity descriptions, hints and guidelines are provided.

Videotapes

The New, Improved Me: Understanding Body Changes videotape and guide. This 21-minute video, shown during Lesson 2.3, is designed to help teens understand and accept pubertal development. The processes of male and female maturation are explained.

No Easy Answers videotape and guide. This videotape explores myths and facts about sexual abuse. Students learn, for example, that sexual abuse is never the fault of the victim, and that anyone can be an offender. Information about programs providing help and support is also provided. It is shown during Lesson 3.6.

For Teens: The Gentle Art of Refusal or *Know-How: A Video on Abstinence for Teens videotapes and guides.* Either of these videos may be shown during Lesson 4.2 to help students learn how to say no to early sexual involvement and other risky activities.

Building Self-Confidence or *I Like Being Me: Self-Esteem videotapes and guides.* Either of these videos may be shown during Lesson 5.5 to introduce teens to the concept of self-esteem.

Rap: We Can Make a Difference videotape and guide. This 14-minute video is used during the second Parent-Youth session. It illustrates the importance of putting oneself in another person's place in order to understand how that person is feeling.

Additional Materials

The PASHA program package provides everything needed to implement *Project TAKING CHARGE*, except for the following materials, which should be available in your school: a TV and VCR, chalkboard or flip chart, markers and pencils. In addition, a variety of arts and crafts supplies will be needed for class activities, including construction paper, magazines, scissors, masking tape and index cards. Finally, it will be helpful to compile and provide students with a list of public health service clinics that diagnose and treat STDs, as well as current state laws concerning confidentiality and mandated reporting.

How to Implement the Program

Teachers should review all of the *Project TAKING CHARGE* materials described above prior to the start of the first lesson. In particular, the *Curriculum* and *Trainer's Manuals* provide a wealth of background information, handouts, worksheets, teacher resources and instructional suggestions for implementing the program.

Studying these materials may provide sufficient preparation for instructors, particularly those who are comfortable and experienced in facilitating group activities and discussions of sexuality with junior high school students. In addition, you may wish to investigate the training programs and materials developed especially for this program by the American Association of Family and Consumer Sciences at (703) 706-4600.

The "Teacher Preparation" section of the *Curriculum Manual* (pages i to xxvi) describes the philosophy, key messages and structure of the program. Of particular value is the unit-by-unit outline for planning each class session.

Organizing the Parent Sessions

Instructors should check with parents to find the most convenient time to schedule the parent-youth sessions. It may be helpful to send home with students a survey that asks parents to select from a choice of times and probes barriers to their attendance, such as transportation and child care. Additional suggestions for maximizing parent participation can be found in the "Parental Involvement" section of the *Trainer's Manual*.

Organizing the Job Shadowing Exercise

Regardless of the option selected, advance preparation will be required for the job shadowing exercise. The "Teacher Preparation" section of the *Curriculum Manual* provides a helpful plan. In particular, instructors may want to use or adapt the sample letters of introduction that are included.

Establishing Ground Rules

Because the success of the program depends upon the comfort level of participants, the first program unit aims to develop group cohesiveness and an open climate for discussion. To establish such an atmosphere, instructors should review the basic concepts described in the *Curriculum Manual*. Teachers should also check their own level of comfort in leading class discussions by reviewing the handout, "*PTC* Teacher Checklist," that appears in the *Trainer's Manual*.

Procedures for establishing ground rules are explained in the *Curriculum Manual*. Teachers are advised to convey the principles listed below and post them on a bulletin board for the duration of the program. The rules are based on the assumption that people feel comfortable when others listen, try to understand what they are saying and display a caring attitude towards them. Still, it is wise not to take big risks (e.g., disclose secrets) if one's level of trust in the group is not high.

(1) Full participation is expected. The program will be fun and successful if everyone participates in class activities and discussions..

(2) Any question is okay—no one should feel afraid to ask a question. It is likely that other students will want to ask the same question. Moreover, in each class period a few questions will be answered from the anonymous question box in the classroom.

(3) Everyone has a right to "pass" on a question or activity. Similarly, no one has to share anything he or she does not want others to know. If a participant feels uncomfortable about answering a particular question, he or she can say "I pass." However, the person will still need to listen to others' answers and take part in the activity.

(4) Respect others' points of view. It is okay to disagree, but not to put down or tease someone. It is all right to laugh with, but not at, someone. Everyone has the right to his or her ideas and opinions.

(5) The sessions will be confidential. Participants should try not to repeat things said during a lesson outside of the class. Students may talk to each other and to family members or friends about the topics and issues discussed, but they should try not to use names (for example, say, "Today in my class, someone said..." instead of "Mary said ...").

Evaluating the Program

The Original Evaluation

Design

The effectiveness of *Project TAKING CHARGE* was investigated in a field study conducted in 1989 with 136 teenagers in Delaware, Mississippi and Ohio. Following a quasi-experimental design, the study compared program participants with a group of their peers who were selected from the same schools, but received no intervention. The researchers compared the two groups of youth on a wide range of measures, including self-esteem, knowledge of sexual development, intentions regarding sexual activity, patterns of communication with parents and educational aspirations. To assess the effectiveness of the program over time, tests were administered to the teens at three points:

- Time 1: Prior to the start of the program (pre-test);
- Time 2: At the conclusion of the program (post-test); and
- Time 3: Six months following the conclusion of the program (follow-up).

Evaluation Questions

The evaluation was designed to measure the degree to which program participants developed the values and skills that would enable them to plan for their future occupations and abstain from sexual activity. In particular, the researchers predicted that program participants would show the following outcomes, relative to the comparison group of peers:

(1) higher self-esteem;

(2) greater understanding of the consequences of early pregnancy for adolescents' educational and vocational plans;

(3) greater knowledge of human sexuality, sexual development and sexually transmitted diseases;

(4) greater clarity of sexual values;

(5) greater intention to postpone sexual intercourse;

(6) more frequent and comfortable communication with parents about sexual issues;

(7) more frequent and comfortable communication with parents about vocational planning; and

(8) higher educational aspirations.

Additionally, the researchers hypothesized similar, positive outcomes for the parents who participated in *Project TAKING CHARGE*. In particular, they predicted that parents would show an increased understanding of human sexuality and sexual development, greater frequency and comfort in communicating with their children about vocational planning and sexual issues and stronger support for postponing early sexual activity.

Recruitment and Data Collection

The researchers recruited a set of family life education teachers at schools in Delaware, Mississippi and Ohio; all had previously been recognized for their superior teaching skills. At the start of the study, one teacher in each site was randomly selected into the treatment group and asked to implement the curriculum and evaluation measures with one of their seventh grade home economics classes. A second teacher in each participating school was randomly selected into the comparison group. These teachers were asked to administer the same set of evaluation instruments, at the same points in time, to one of their seventh grade home economics classes. However, no intervention was given to these classes.

Sample

The research sample included 136 teens: 77 program participants and 59 comparison group members. Of the 126 parents who participated, 69 were included in the program group and 57 in the comparison group. Across sites, the number of participants in the treatment and comparison groups varied, ranging from a low of 14 teenagers (and 13 parents) in the Delaware comparison group, to a high of 27 teenagers (and 27 parents) in the Mississippi treatment group. There was no attrition among the teens, and only two parents failed to complete the post-test assessment.

Approximately equal numbers of male and female students were included in the final research sample. On average, the youth were either 12 or 13 years of age, living with both parents, and White. However, more than one-third were minority group members, predominantly African-American.

Evaluation Results

At the start of the study, less than one-fourth of the teens reported previous sexual activity. For those who were active (15 in the treatment group and 12 in the comparison group), the average age at first intercourse was approximately 11 years. In addition, the researchers found few social or demographic differences between program participants and members of the comparison group. They did note, however, that comparison group teens were more likely to believe that parents opposed sexual intercourse during adolescence, and program participants showed higher levels of self-esteem.

Knowledge Measures

Compared to their peers who received no intervention, at the Time 2 assessment, program participants showed greater gains in their understanding of sexual development and STDs ($p<.001$), sexual anatomy and physiology ($p<.001$) and the complications that can result from teen pregnancy ($p<.05$). Moreover, these gains were largely maintained six months following the conclusion of the program.

Initiation of Sexual Intercourse

Participation in *Project TAKING CHARGE* may have delayed the initiation of sexual intercourse for teens who had not yet begun having intercourse at the start of the study. The researchers found that 50% of comparison group students who were abstinent at the Time 1 assessment had become sexually active by the final assessment period. In contrast, the figure for program participants was 23%. However, the actual numbers of students in the two groups was small, and the statistical test fell just short of significance ($p=.051$).

On all other measures—including self-esteem, educational aspirations, clarity of sexual values, intentions regarding sexual activity and communication with parents regarding sexual intercourse and vocational aspirations—the researchers found no difference between the two groups of teens.

Effects on Parents

At the follow-up assessment, parents who participated in *Project TAKING CHARGE* showed significant gains in their knowledge of sexuality and sexually transmitted diseases, relative to the comparison group of adults. However, the treatment and comparison groups did not differ on measures of communication about sexual issues with teens.

Summary

Overall, both youth and adult participants in *Project TAKING CHARGE* showed increased knowledge of sexual development, STDs and sexual anatomy and physiology at the conclusion of the program. These gains remained strong six months following the intervention. Teens also demonstrated an increased understanding of the complications caused by early pregnancy. In addition, the researchers presented some evidence to suggest that *Project TAKING CHARGE* may have promoted abstinence among teens who had not yet begun having intercourse at the start of the study. They noted, however, that a significance test between participants and their comparison group peers fell just short of significance ($p=.051$).

The researchers had predicted other positive outcomes for program participants, but the intervention appeared to have no effect on participants' self-esteem, educational aspirations, clarity of sexual values, intentions regarding sexual activity or communication with parents regarding sexual intercourse and vocational aspirations.

Evaluation Materials for *Project TAKING CHARGE*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the instruments used in the original evaluation, the *Prevention Minimum Evaluation Data Set (PMEDS)* and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

Student Questionnaires. The pre-test survey includes a few background demographic questions, followed by measures of students' self-esteem, future academic and career plans, comfort in speaking with their parents about vocational aspirations and sexuality, and knowledge, attitudes and values about sexuality. The same instrument can be used with program participants and the comparison group of teens.

In addition, separate post-test instruments are included for program participants and members of the comparison group. Most of the questions are identical to those included in the pre-test. Each instrument can be used immediately following the conclusion of the program and again, at the six-month follow-up assessment.

Parent Questionnaire. This survey measures adults' perceptions of their communication with their child about vocational planning, sexual activity and sexual values. Separate instruments are included for the pre-test and post-test assessments.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Project TAKING CHARGE*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

3

Reducing the Risk

An Adolescent Pregnancy & STD/HIV/AIDS Prevention Program

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Program Abstract

Title

Reducing the Risk

Summary

Reducing the Risk is a high-school-level sexuality education curriculum designed to reduce the frequency of unprotected sexual intercourse through: (1) delaying or reducing the frequency of intercourse or (2) increasing contraceptive and STD-protection practice. The 16-session curriculum is intended to serve as one component of a comprehensive sexuality education course, rather than as a comprehensive, stand-alone program. Based on social learning theory, the curriculum aims to change student norms about unprotected sex and perceptions of peer sexual activity, as well as to strengthen parent-child communication concerning abstinence and contraception. The curriculum explicitly emphasizes that students should avoid unprotected intercourse, either by not having sex or by using contraceptives. Lessons are reinforced through role-plays, homework activities, quizzes, and skill-building activities.

A field study of the program was conducted in 13 California high schools. Participation in the program significantly increased teens' knowledge and communication with parents regarding abstinence and contraception. In addition, the program significantly reduced the likelihood that students who had not had intercourse at the start of the program would become sexually active by the 18-month follow-up assessment. However, program participation did not affect the frequency of sexual intercourse or the use of contraceptives among teens who were already sexually active at the start of the program.

Focus	☑ Primary pregnancy prevention	☐ Secondary pregnancy prevention	☑ STD/HIV/AIDS prevention
Original Site	☑ School-based	☐ Community-based	☐ Clinic-based

Suitable for Use In	Although the program was originally designed for high schools, it is equally suitable for use in community-based organizations.
Approach	☑ Abstinence ☑ Behavioral Skills Development ☐ Community Outreach ☐ Contraceptive Access ☑ Contraceptive Education ☐ Life Option Enhancement ☐ Self-Efficacy/Self-Esteem ☑ Sexuality/HIV/STD Education
Original Intervention Sample	Age, Gender: The field study included male and female high school students (avg. age=15 years). Race/ Ethnicity: 61% White, 21% Latino, 9% Asian, 2% African-American, 6% other.
Program Components	☑ Adult Involvement ☐ Case Management ☑ Group Discussion ☑ Lectures ☐ Peer Counseling/Instruction ☐ Public Service Announcements ☑ Role Play ☐ Video ☑ Other Clinic and store visits
Program Length	The program consists of 16 lessons, each designed for a 45-minute class period. Most lessons can be expanded to fill two class periods by increasing practice and discussion time.
Staffing Requirements/ Training	Regular classroom teachers lead the program. During the original field study, teachers attended a three-day training session, which focused primarily on practice of the role plays and other class activities. The training also included three hours of instruction in reviewing procedures both for obtaining parent and student consent, and for collecting program evaluation data.
How to Obtain this Program	The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

Reducing the Risk is a high-school-level sexuality education curriculum that is designed to reduce the frequency of unprotected sexual intercourse through: (1) delaying or reducing the frequency of intercourse or (2) increasing contraceptive practice. The 16-session curriculum is intended to be used as one component of a comprehensive sexuality education course, rather than as a stand-alone program.

The curriculum aims to change student norms about unprotected sexual intercourse and perceptions of peer sexual activity; develop effective skills to delay intercourse and/or refuse unprotected sex; and improve parent-child communication concerning abstinence and contraception. The curriculum explicitly emphasizes that students should avoid unprotected intercourse, either by not having sex or by using contraceptives. Active student participation is required in role-play situations that simulate those likely to be encountered outside the classroom. Homework assignments provide further reinforcement of class lessons.

A field test of *Reducing the Risk* was conducted during the 1988-1989 school year in 13 California high schools. Funding for the study was provided by the Stuart Foundation, the William and Flora Hewlett Foundation and the National Institutes of Health.

Theoretical Framework

Reducing the Risk is based on Social Learning Theory, which asserts that the likelihood of engaging in some action, such as using birth control, is determined by four factors:

(1) a person's understanding of what must be done to avoid pregnancy;

(2) the belief that one will be able use the method;

(3) the belief that the method will be successful at preventing pregnancy; and

(4) the benefit one anticipates from accomplishing the behavior (e.g., preventing pregnancy through effective contraception).

Another important tenet of social learning theory is that people learn skills by observing others' behavior and then imitating them. In

Reducing the Risk, teachers and peers first model socially desirable behaviors, such as using birth control; students then practice those behaviors in role plays.

This theory suggests that students need to develop the specific cognitive and social skills that will enable them to resist pressures and successfully negotiate interpersonal encounters. *Reducing the Risk* provides instruction and practice in using the skills needed to prevent pregnancy and reduce unsafe behavior in high-risk situations. For example, students are given opportunities to practice obtaining birth control information from stores and clinics.

Program Objectives

After completing the program, students should be able to:

- evaluate the risks and consequences of becoming an adolescent parent or becoming infected with HIV/AIDS or another STD;
- recognize that abstaining from sexual activity or using contraception are the only ways to avoid pregnancy, HIV infection and other STDs;
- conclude that factual information about conception and protection is essential for avoiding teen pregnancy, HIV infection and other STDs; and
- demonstrate effective communication skills for remaining abstinent and for avoiding unprotected sexual intercourse.

Program Content

Reducing the Risk uses modeling and repeated practice to enhance teens' skill in resisting unprotected intercourse. Program lessons continually reinforce the message that youth should avoid unprotected intercourse, that the best way to do this is to abstain from sex, and that youth who do not abstain from sex should use contraceptives to guard against pregnancy and sexually transmitted diseases. Students also participate in activities that are designed to personalize the consequences of pregnancy and HIV infection. Finally, the curriculum seeks to improve parent-child communication about abstinence and contraception.

With its primary emphasis on skill development, *Reducing the Risk* includes instruction in:

- Refusal Statements: Students learn to say "No" clearly, in a manner that maintains a good relationship but leaves no ambiguity about the speaker's intent to abstain from sex or unprotected intercourse.
- Delay Statements and Alternative Actions: Students learn ways to avoid situations altogether or delay taking acting until they have had either sufficient time to decide what to do or say, or until they are prepared to implement a decision.

63

Program Schedule

The program curriculum spans 16 classes or lessons. Lessons are designed for 45-minute class periods but can be easily expanded to two periods by increasing practice and discussion time. A brief overview of the lessons is provided below.

Description of Program Sessions

CLASS 1: Abstinence, Sex and Protection—Pregnancy Prevention Emphasis

During this introductory class, the teacher demonstrates refusal skills through two versions of a role play. Students also participate in a two-part "pregnancy risk" activity to personalize their vulnerability to pregnancy.

There are two options for Class 1. "Class 1" focuses on pregnancy prevention. "Alternate Class 1" focuses on HIV/AIDS prevention.

ALTERNATE CLASS 1: Abstinence, Sex and Protection—HIV Prevention Emphasis (can be substituted for Class 1 or used in addition to Class 1).

The teacher models two versions of a role play to demonstrate refusal skills for preventing HIV infection. Students participate in an "HIV Risk" activity to personalize their vulnerability to HIV/AIDS and to symbolically experience modes of transmission.

CLASS 2: Abstinence: Not Having Sex

Students learn that there are only two ways to avoid pregnancy and HIV: not having sexual intercourse (abstaining), or consistently using protection. This session focuses on the advantages of abstinence. Reasons why teens fail to abstain or protect themselves during intercourse are also considered. Students discuss elements of successful male-female communication about abstinence, and they practice identifying successful communication strategies.

CLASS 3: Refusals

This class introduces both nonverbal and verbal communication skills for refusing sexual activity. Participants watch a demonstration of social skills that are important to abstaining and using protection. Finally, they practice and study five characteristics of effective refusals. The homework assignment, "Talk to your parents," encourages students and their parents to discuss their sexual attitudes and values.

CLASS 4: Using Refusal Skills

After students are quizzed on refusal skills, they use role plays to practice applying these skills in difficult situations.

CLASS 5: Delaying Tactics

After observing a demonstration, students practice delaying skills in role play situations. Participants' progress is evaluated with a short quiz.

CLASS 6: Avoiding High-Risk Situations

Through a class discussion and mini-lecture, students identify "yellow alert" and "red alert" situations that can lead to unwanted or unprotected sex. Students practice dealing with the two types of alert situations with the worksheet "Handling Crisis Situations." A second worksheet, "Protection: Myths and Truths," encourages teens to protect themselves from pregnancy, HIV, AIDS and other STDs.

CLASS 7: Getting and Using Protection—I

This class uses lectures and demonstrations to provide teens with information on methods for protecting against unplanned pregnancy, HIV, AIDS, and other STDs. For homework, students are asked to research prices and descriptions of non-prescription contraceptive products.

CLASS 8: Getting and Using Protection—II

The first half of Class 8 includes a discussion and visual demonstration of prevention methods, specifically for preventing HIV/AIDS. During the second half of the class, students learn how to locate local clinics for information about protection. They are also asked to evaluate which methods might be best for them. As an additional option, this lesson may include a guest speaker from, or a field trip to, a nearby clinic.

CLASS 9: Knowing and Talking about Protection: Skills Integration—I

This is the first of three lessons in which students apply the communication skills they have learned in the program. A quiz on protection methods is also included. Finally, students watch role plays in which friends talk to each other about issues related to sex and discuss ways to handle similar situations with their own friends.

CLASS 10: Skills Integration—II

Additional opportunities are provided for teens to practice saying "No" and making decisions about protection. Students may also take part in partially scripted role plays involving difficult situations.

CLASS 11: Skills Integration—III

Students use worksheet and role play exercises to practice handling situations that might lead to unprotected sex.

CLASS 12: Preventing HIV/AIDS and other STDs

Working in small groups, participants explore information about five specific STDs. The groups compare forms of transmission, prevention, and treatment for the five diseases.

CLASS 13: HIV/AIDS Risk Behaviors

Class activities are designed to help students apply their knowledge about HIV/AIDS transmission and identify which behaviors put them at greatest risk for exposure to the virus. Students place behaviors on a continuum of risk, from no risk to risky, and discuss why certain behaviors are more risky than others.

CLASS 14: Protecting Oneself from STDs and Pregnancy

This session includes several activities to help students develop plans for preventing pregnancy and reducing STD risk through the use of a condom. Participants write role play scripts for scenes involving protection with condoms.

CLASS 15: Sticking with Abstinence and Protection

Students report on two homework assignments in which they are asked to find information about protection. The teens discuss and practice the "self-talk" method that is designed to help them plan and then follow their plan to avoid sex or unprotected sex.

CLASS 16: Skills Integration—IV

A discussion about sticking with choices and a final role play situation provide two opportunities for students to practice avoiding intercourse or unprotected sexual activity.

Program Materials: Replicating or Adapting *Reducing the Risk*

The *Reducing the Risk* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of this book. The package includes the following program materials needed to implement *Reducing the Risk* in your school or community: a *Teacher's Handbook*, a *Student Workbook* and two pamphlets—*STD Facts* and *HIV: Get the Answers*. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Teacher's Handbook

Reducing the Risk—Building Skills to Prevent Pregnancy, STD & HIV (Teacher's Handbook), contains the curriculum material for *Reducing the Risk*. The curriculum is divided into the 16 class sessions described above.

71

For each class, the *Teacher's Handbook* provides a synopsis of activities, the approximate time required for each activity, materials needed, detailed instructions for leading each activity, student worksheets and handouts, role play scripts, teacher references, and homework assignments.

Student Workbook

Reducing the Risk—Building Skills to Prevent Pregnancy, STD & HIV (*Student Workbook*), contains the same worksheets, homework assignments, role plays and quizzes that are included in the *Teacher's Handbook*. You may choose whether to provide students with their own copies of this book or make photocopies from the *Teacher's Handbook*.

Information Pamphlets

Two pamphlets (25 copies of each) are recommended for use during Class 12—*STD Facts* and *HIV: Get the Answers*. Both provide additional information to supplement the class lesson.

Additional Materials

All of the above curriculum materials for *Reducing the Risk* are included in the PASHA program package. To implement the program, you will also need the following items, which should be readily available in your school or community: a chalkboard or flipchart with markers, photocopier, index cards in a variety of colors, local telephone directories, and condoms and foam for demonstration.

How to Implement the Program

Instructors should read all program materials (*Teacher's Handbook*, *Student Workbook* and *information pamphlets*) prior to the first class.

It is essential that instructors read the section "Prior to Class 1" in the *Teacher's Handbook* to familiarize themselves with critical issues regarding state and district laws, parental consent, ground rules for classroom discussion and strategies for effective role-plays.

Obtaining District and Parent Support

The subject matter of *Reducing the Risk* may provoke controversy, and instructors should make certain that they understand and apply district policies and state mandates before beginning the program. School board approval and administration support are equally essential.

Informed consent from students and their parents is critical when using the *Reducing the Risk* curriculum. The *Teacher's Handbook* offers tips and guidelines for this process.

Establishing Classroom Ground Rules

Ground rules for classroom discussion should be established at the start of the program. This will create an atmosphere of trust and comfort in which students feel free to discuss sexuality, birth control and protection from sexually transmitted disease.

Procedures for establishing ground rules are explained in the *Teacher's Handbook*. Instructors are advised to follow the principles listed below:

- Students have the "right to remain silent" about any thoughts and actions that they wish to keep private.
- Every question is a good question; every comment is worthy of consideration.
- Teasing, putting down or discussing other class members' comments inside or outside the classroom will not be tolerated.
- The teacher will respect the confidentiality of students' comments (within the constraints permitted by law).
- Students who have, or are aware of, a concern, complaint or question about the class are encouraged to discuss it with the teacher as soon as possible.
- When discussing issues raised in class with parents, students should provide as accurate a description as possible.
- Because role plays are based on fictional situations, students may say things, as actors, that they would not otherwise say. Therefore, nothing said in any role play exercise should be taken as a sign of interest in having a relationship or having sex.

Importance of Role Playing

Practicing newly-learned skills is a critical piece of the *Reducing the Risk* curriculum. Because situations that could potentially lead to unprotected sex are much more powerful in real life than in the classroom, students must "overlearn" refusal and delay skills. Extensive practice increases students' chances of being clear and forceful in real-life romantic situations. Several strategies for increasing practice opportunities are discussed in the *Teacher's Handbook*.

Evaluating the Program

The Original Evaluation

Design

The impact of the *Reducing the Risk* program was measured in a field test conducted with 758 students enrolled in 13 California high schools. A diverse set of measures was used to compare the knowledge, attitudes, and behaviors of two groups of teens: (1) students who took part in the *Reducing the Risk* program (the *treatment* group) and (2) students who received their school's standard sexuality education curriculum (the *comparison* group). Questionnaires were administered to all teens at four points in time:

- Time 1: Before the *Reducing the Risk* program began;
- Time 2: At the conclusion of the program;
- Time 3: About 6 months following the program; and
- Time 4: About 18 months following the program.

Recruitment Procedures

To recruit schools for the study, program evaluators sent letters of inquiry to 252 high schools in the 140 California school districts with existing sexuality education programs. To be eligible to participate, schools had to have at least two sexuality education classes, so that one could be included in the treatment group while the second could serve as the comparison group.

Thirty-two high schools expressed strong interest in the study. However, since concerns about the subject matter discouraged many from participating, the final sample included 13 schools. Among the schools that ultimately declined to participate, two reasons were most common: (1) pressure from interest groups concerned about the inclusion of birth control in the curriculum; (2) reluctance to use the student questionnaire, which was not anonymous and which included questions about sexual intercourse and pregnancy. You and your staff may want to anticipate similar concerns when using *Reducing the Risk* in your own community.

Within the participating schools, teachers volunteered to use the curriculum in their classes. During a three-day training session held at the start of the study, instructors practiced program exercises and reviewed procedures for obtaining parental and student consent and administering the student survey.

Individual classes were assigned to either the treatment or comparison group; whenever possible, the assignment was random.

In schools where classes were unequal in size, the larger classes were assigned to the treatment group to maximize the power of the statistical analysis.

Minimizing Potential "Contamination Effects"

About half of the comparison classes were taught by teachers who also taught one or more treatment classes; this arrangement had implications for the statistical analysis. Although researchers could control for the teachers' general experience and teaching style in their analysis, they could not eliminate possible "contamination" effects. Contamination would result if teachers brought treatment material and techniques into their comparison group classrooms. The researchers tried to address this issue by carefully and repeatedly instructing teachers who taught both treatment and comparison classes not to incorporate any of the *Reducing the Risk* techniques into their comparison classes during the study period.

At the same time, by having some control classes taught by treatment teachers and some by other teachers, the evaluators hoped to reduce potential threats of contamination and differential teaching ability; the researchers reasoned that these biases might cancel, rather than reinforce, each other.

Data Collection Procedures

Participation in the study required "active consent" from students and their parents; meaning that parents had to sign a permission slip allowing students to participate. Parents were invited to learn more about the curriculum and the evaluation study at an information session that was held in the evening at their child's school. Across all participating schools, fewer than 1% of students were excluded from the program because their parents withheld permission.

The Time 1 and Time 2 assessments were completed by students in their classrooms. The 6-month and 18-month follow-up assessments were conducted in two ways. Some students were recruited by their teachers to complete the survey in school. The remaining students, who received the survey at home, were contacted by telephone to encourage them to return the questionnaire. At the 6-month follow-up, about 25% of students were contacted at home; at the 18-month follow-up, the percentage had increased to more than 50%. Some youth were called more than a dozen times by research staff before responding.

Original Intervention Sample

A total of 46 classes from 13 high schools in 10 school districts participated in the field test. At pre-test, 1,033 students completed the assessment (586 in the treatment group and 447 in the comparison group). A total of 758 students, or 73% of the original sample, completed the pre-test and 18-month surveys. The researchers found that students who did not complete the 18-

month follow-up differed from the other teens in several important ways: at pre-test, they were more likely to be older, more likely to be male, more likely to have poor grades, less likely to live with both parents, more likely to have had sex, more likely to have failed to use birth control because sex was not planned, and less likely to have talked to their parents about abstinence.

Evaluation Results

The results indicate that the *Reducing the Risk* curriculum had significant effects in several areas, particularly parent-child communication, knowledge and the initiation of intercourse.

Effects on Parent-Child Communication

Participation in the program increased teens' communication with their parents about abstinence and birth control. Although comparison group students also showed an increase in communication with their parents over time, the gain among program participants was significantly greater, even 18 months after the intervention. Both parents and students reported that the program made it easier for them to communicate; for many families, this was the first time they had discussed abstinence and birth control at home.

Effects on Knowledge

Many sexuality education programs produce significant gains in student knowledge. Nevertheless, the gains measured in *Reducing the Risk* are noteworthy for three reasons. First, the curriculum did not focus upon knowledge acquisition, but rather, on role-playing exercises. Second, comparison group students also received sexuality education, yet the gains recorded for *Reducing the Risk* students were significantly greater. And third, the effects remained significant through the 18-month follow-up assessment.

Effects on Peer Norms

One of the goals of this norm- and skills-based curriculum was to change norms regarding unprotected sex and to change students' perceptions that "everyone is doing it." Although the curriculum did not seem to diminish students' perceptions about sexual activity among their peers, it apparently prevented those perceptions from worsening over time.

Effects on Initiation and Frequency of Sexual Intercourse

The curriculum apparently reduced the chance, possibly by as much as 24%, that a student would initiate intercourse. Moreover, contrary to the fears of some of its opponents, the curriculum did not increase the frequency of intercourse among students who had already become sexually active. In addition, the curriculum appeared to reduce unprotected intercourse among lower-risk students, although no decrease in the overall frequency of sexual activity was recorded.

Effect on Contraceptive Use

Overall, the data indicate that the curriculum did not affect the use of birth control at first intercourse or at most recent intercourse, nor did it affect the frequency of contraceptive use. However, among the subset of teens who became sexually active following the study, program participants were more likely to use contraception.

Summary

The empirical results show that the 16-session *Reducing the Risk* curriculum, which emphasizes skill development for resisting unprotected intercourse, can be an effective component of a comprehensive sexuality education program. Program participants showed clear gains in knowledge and improved communication with their parents (at least about the specific issues of abstinence and contraception addressed in homework assignments). The curriculum also delayed intercourse among teens who had not already become sexually active at the start of the intervention.

Among the relatively few students who did initiate intercourse following the study, *Reducing the Risk* participants were more likely than comparison group students to use contraception. However, the curriculum did not significantly affect the frequency of sexual intercourse or the use of birth control among those who had initiated intercourse before the study began.

Overall, the results are particularly impressive in light of the fact that most comparison group students received traditional sex education (rather than no intervention at all). Thus, the field study suggested that *Reducing the Risk* was more effective at producing behavioral changes than the more traditional curricula.

Evaluation Materials for *Reducing the Risk*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instrument*, the *Prevention Minimum Evaluation Data Set (PMEDS)*, and *The Local Evaluator Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

The Original Evaluation Instruments

The *Original Evaluation Instruments* are comprised of the student questionnaires used by the original investigators. There are two versions of the questionnaire: a boy's version and a girl's version. Both forms include the same content, but the wording is adapted to the sex of the respondent.

The 90-item instrument is designed to assess contraceptive knowledge, intentions to avoid unprotected sex in high-risk situations, communication with parents, and sexual and contraceptive practices. Related items assess teens' use of alcohol.

During the field study, the same questionnaire was administered to participants before the program began, immediately after the program concluded, 6 months after the program, and finally, at 18 months after the program.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Reducing the Risk*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

4

Reproductive Health Counseling for Young Men

An Adolescent Pregnancy Prevention Program

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Bibliography	Danielson, R., Marcy, S., Plunkett, A., Wiest, W., & Greenlick, M.R. (1990). Reproductive health counseling for young men: What does it do? *Family Planning Perspectives*, 22(3), 115-121.

Program Abstract

Title

Reproductive Health Counseling for Young Men

Summary

Originally developed for boys between 15 and 18 years of age, this is a one-hour, single-session, clinic-based intervention. The program is designed to meet the needs of sexually active and inactive teens, and to promote abstinence as well as contraception. The session begins with a video presentation that is viewed privately by each teen. The materials address reproductive anatomy, fertility, hernia, testicular self-examination, STDs (including HIV/AIDS), contraception (including abstinence), communication skills and access to health services. A half-hour private consultation with a health care practitioner follows the presentation. Guided by the young men's interests, the consultation may include such topics as sexuality, fertility goals and reproductive health risks, along with rehearsal and modeling of sexual communication.

A field study of the intervention was conducted with 1,195 high school-aged males visiting health maintenance organizations in two Northwestern cities. Compared to a control group of their peers, sexually active program participants were significantly more likely to use effective contraception at the one-year follow-up assessment, especially if they were not yet sexually active at the time of the intervention. The sexual partners of program participants were also more likely to use effective contraception at the follow-up. Among participants who remained abstinent, the young men reported greater comfort with their decision to delay sexual involvement than did their control group peers.

Focus ☑ Primary pregnancy prevention ☐ Secondary pregnancy prevention ☐ STD/HIV/AIDS prevention

Original Site ☐ School-based ☐ Community-based ☑ Clinic-based

Suitable for Use In

This program is suitable for use in hospital- or community-based clinics.

Approach

☑ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☑ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☑ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age, Gender	The field study involved 1,195 adolescent males ranging in age from 15 to 18 years.
Race/ Ethnicity	91% White, 5% African-American, 4% Asian, 1% other.

Program Components

☐ Adult Involvement
☐ Case Management
☐ Group Discussion
☐ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☑ Role Play
☑ Video
☑ Other Private counseling session

Program Length

The intervention is one hour in length, evenly divided between the counseling session and video presentation.

Staffing Requirements/ Training

Health care practitioners serve as counselors and provide a brief introduction to the video presentation. In the field study, special training was held to introduce staff to the program's "developmental counseling" strategies, as well as to review the slide and tape presentation. Throughout the study, one of the program leaders was available to answer questions and lead occasional staff meetings.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

Program Rationale and History

The *Reproductive Health Counseling for Young Men* program was developed to fill a gap in existing teen pregnancy prevention efforts—notably the involvement of adolescent males. The program was originally targeted toward young men between the ages of 15 and 18, regardless of their previous sexual experience. All intervention activities took place within a single, regularly scheduled medical appointment at participating health maintenance organizations in Portland, Oregon and Vancouver, Washington.

Guided by the belief that health care practitioners can serve as credible sources of sexuality information, the program provides reproductive health information and counseling in a primary health care setting. The two-part, single-session intervention takes a broad approach; rather than focusing narrowly on abstinence or (for sexually active young men) contraception, it is also designed to improve participants' knowledge of sexuality and STD prevention, and to promote the practice of testicular self-examination. The intervention further aims to improve teens' skills and attitudes by encouraging and providing practice in couple communication, as well as promoting greater empathy for female development.

A field study of the intervention was conducted between 1985 and 1987 in Northwest Region Kaiser Permanente, a health maintenance organization serving more than 300,000 members in the Portland, Oregon and Vancouver, Washington regions. Approximately 1,200 males, ages 15-18, participated in the study. Funding was provided by the Office of Family Planning, US Department of Health and Human Services.

Theoretical Framework

The *Reproductive Health Counseling for Young Men* program is grounded in previous research demonstrating that teens, parents and health care professionals believe that health maintenance organizations can provide valuable reproductive health information and services to teens. In an earlier project, an HMO had developed a number of innovations, including teen clinics; enhanced access to women's health services and contraception; aggressive attention to women seeking pregnancy testing; newsletters, films and forums for teens and parents; and extensive community outreach. However, the researchers found that very little attention was ever given to males, despite abundant opportunity, especially in medical visits. Informal research revealed that staff felt less comfortable addressing sexual health topics with young men than they did with women.

The developers of the *Reproductive Health Counseling for Young Men* program further recognized the importance of male involvement in contraception. Studies had found that "male" methods—condoms and withdrawal—were the most widely used methods of contraception in many teenagers' earliest sexual experiences, and a variety of studies illustrated how women's partners' concerns were relevant to their use of different contraceptive methods. For these reasons, the program developers hoped to reach and educate adolescent men, especially in their role as partners of young women.

The program is further guided by principles of "developmental counseling." This approach seeks to tailor advice and support to the psychosocial and cognitive level of the client, yet provide directive advice for urgent situations. Additionally, counselors strive for discussions that are interactive, concrete and grounded in the client's personal concerns. In previous research, this method had proved more effective than traditional medically-oriented consultations with youth.

Finally, highly explicit information and photography are used in the intervention to enhance youths' attention and to distinguish this material from other, more general sex education they may have experienced. The original program developers believed that the provision of such "manly" knowledge would be appropriate for the private, medical setting in which it was to viewed. They reasoned that this approach might assuage some of the curiosity of youth with little or no sexual experience. Moreover, they hoped it would reduce virgins' "sexual impatience," boost their sense of manly adequacy and reduce pressures to begin having intercourse.

Program Objectives

The *Reproductive Health Counseling for Young Men* program embraces five educational objectives:

(1) to promote abstinence, contraception and prevention of STD/HIV/AIDS;

(2) to serve both sexually active and abstinent teens;

(3) to appeal both to youth and their parents;

(4) to address the educational and counseling needs of young men without labeling them as sexually active/inactive or as having sexual problems; and

(5) to promote sexual and reproductive health, broadly defined.

Program Components

The one-hour intervention is divided into two 30-minute components: a video presentation followed by a counseling session. During the original field study, these activities took place within a regular scheduled medical appointment at a health care facility. Additional information about each component can be found in an accompanying *Program Manual*.

Video Presentations

Following a brief introduction and greeting by a health care practitioner, the teen views a video program privately, in an examination or conference room. The presentation explicitly addresses reproductive anatomy, fertility, hernia, testicular self-examination, STDs (including HIV/AIDS), sexuality and contraception (including abstinence), communication skills and access to health services. It was partly adapted from "Young Men's Reproductive Health" and "Young Men's Sexual Responsibility," both created by researchers at the University of Minnesota School of Public Health.

Counseling Session

Immediately following the video, the health care practitioner returns for a private consultation and counseling session with the teen. Although the session typically focuses on abstinence and/or contraception, it should be guided by each participant's expressed interests and may cover such topics as sexuality, fertility goals, symptoms of sexually transmitted disease and appropriate use of health care resources. In an effort to enhance teens' familiarity and comfort with contraception, samples of condoms and other products should be shown. Be sure to invite teens to ask any questions they may have. Finally, have staff model effective communication with one's partner and then encourage the youth to practice these skills.

Program Materials: Replicating or Adopting *Reproductive Health Counseling for Young Men*

The *Reproductive Health Counseling for Young Men* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of this book. The package includes the materials needed to implement the program in your hospital, school, or community-based clinic. The *Reproductive Health Counseling for Young Men Program Manual* provides detailed plans to guide you in setting up the video presentation and in facilitating the personal counseling sessions. Helpful advice for training staff in the techniques of "developmental counseling" is also provided. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Video

The 30-minute video includes highly explicit information and photography to enhance youths' attention and to distinguish this material from other, more general sex education they may have experienced. You may want to preview the material to ensure that it is suitable for the teens you serve and the setting in which you work.

Program Script

The printed script contains the same information as is heard on the video. This may be a helpful reference for program planning and training with staff.

Additional Materials

The PASHA program package provides everything needed to implement the *Reproductive Health Counseling for Young Men* program, except for a TV and VCR, which should be available in your clinic or HMO. In addition, you will need samples of contraceptive devices, including condoms, spermicide and birth control pills, to show participants during the counseling session.

How to Implement the Program

Developmental Counseling

During the field study, program staff aimed to be directive but not judgmental during the counseling session, and to address any questions or concerns the youth might have. This "developmental" approach—first used with young women—offers highly explicit advice. Moreover, it differs significantly from traditional reproductive counseling, which typically concentrates on the medical history of the teen. More information about this approach—including sample responses to young men's questions and strategies for dealing with embarrassment or silence—can be found in the *Program Manual*. Make sure that you and your staff are comfortable using this approach before beginning your implementation.

Underlying Principles

The following principles—elaborated in the *Program Manual*—were used by the original program developers to set up and carry out the intervention. They may prove helpful for your own intervention.

(1) Take a positive view of adolescence and sexuality.

(2) Acknowledge sexual development as one of the tasks of adolescence.

(3) Take a broad and positive view of sexuality.

(4) Counseling should be tailored to the cognitive skills of teens.

(5) Emphasize couple communication, shared responsibility and personal responsibility.

(6) Encourage young men to understand and empathize with their female partners' experiences.

(7) Recognize the high esteem and trust given to health care professionals regarding health issues.

(8) Teach teens how and when to access health care services, and invite them to practice discussing reproductive and sexual health issues with health care professionals.

Updating the Presentation

You may wish to update or supplement the video presentation to incorporate current knowledge about STD/HIV/AIDS prevention, as well as new methods of birth control, such has Norplant, DepoProvera, the female condom and emergency contraception. Some suggestions and guidelines are included in the *Program Manual*.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of *Reproductive Health Counseling for Young Men* was investigated in a field study conducted in two Northwestern cities between 1985 and 1987. The study compared two groups of males: adolescent males who took part in the single session video and counseling intervention (e.g., program participants) and members of a control group put on a waiting list for the program. Assignment to the two groups was randomly determined.

The researchers investigated the two groups' knowledge of reproductive health, levels of sexual activity, contraceptive use and (for abstinent males only) sexual impatience, or feelings about having never engaged in intercourse. Surveys were administered to all teens at two points:

- Time 1: at the youth's recruitment into the study (pre-test); and
- Time 2: twelve months following the intervention (follow-up).

Evaluation Questions

The researchers hypothesized that program participants would show significant improvement on the following measures, relative to their control group peers:

(1) knowledge of reproductive health;

(2) delay in sexual debut;

(3) use of contraception if sexually active; and

(4) acceptance of postponed sexual debut.

Recruitment and Data Collection

Young men were recruited by telephone from the population of high school-aged males whose names appeared on active appointment schedules for routine medical services at a large health maintenance organization. The plan for participating in the program and completing questionnaires was described to each youth and at least one parent. Consent was then requested and confidentiality was assured for the information provided on all research instruments. The young men were also promised a $15 travel allowance following completion of the final questionnaire.

With teens who had been randomly assigned to the treatment group, visits were scheduled immediately. For teens assigned to the control group, staff explained that they would call back to arrange an appointment at a later time.

Unless there was a refusal, at least three attempts were made to schedule appointments with each youth. If the client seemed reluctant to schedule a visit, the scheduler asked if the client would prefer to see a male practitioner or a physician instead of a nurse practitioner. In only a few cases did this happen, and these youths were served accordingly. In a few cases, the young man asked to bring a friend or brother along, and this was welcomed.

Staff attempted to re-schedule all missed appointments. However, with reminder calls, missed appointments were not a problem, and 81% of teens assigned to the treatment group eventually participated.

All youth were asked to complete the pre-test survey at the time of their recruitment into the study, and the follow-up survey twelve months later.

Research Sample

Of the 2,602 potential participants identified by the researchers, 94% were reached by phone, and 56% provided the necessary consent. Scheduling was successfully completed for 1,195 teens, or 46% of the original pool. The final research sample was predominantly middle-class and White, though 5% of participants were African-American and 4% Asian. At the pre-test assessment, 18% of the youth were high school freshmen, 45% sophomores, 24% juniors and 24% seniors.

After discarding 23 surveys which could not be matched to baseline instruments, the researchers were left with complete data from 971 teens, or 81% of the initial sample. Overall, the demographic characteristics of the final research sample were similar to those of the HMO population in this age category, except that high school sophomores were over-represented.

Evaluation Results

Knowledge of Reproductive Health

Analysis of data provided evidence of statistically significant effects on teens' understanding of contraception, sexually transmitted disease, fertility, transmission and prevention of HIV/AIDS. However, most of these effects were significant only among particular subgroups of participants. For example, program participants were significantly more likely than their control group peers to believe that the birth control pill is very safe ($p<.01$). However, this belief was significant only among those teens who had already become sexually active when the study began. In contrast, on items measuring teens' understanding of fertility, newly sexually active program participants scored significantly higher than their control group peers ($p<.01$). Finally, on a seven-item index of HIV/AIDS-related knowledge, participants showed a modest improvement, relative to the control group. This finding was significant for the entire group of participants ($p<.05$).

Sexual Activity Status

There were few differences in patterns of sexual activity between program participants and members of the control group—at either assessment period. Thus, it appeared that the intervention neither encouraged nor discouraged sexual activity by the teens. Across the two groups, slightly more than one-third (37%) were sexually active during the year prior to the study, and 53% were active during the follow-up period. Among teens who had been abstinent at baseline, 31% were active at the follow-up assessment, while 90% of teens were sexually active at the pre-test remained so through the study period. Although fewer virgins in the intervention group became active in the follow-up year than in the control group, this difference was not statistically significant.

Contraceptive Use

In contrast, the program did appear to have a positive impact on sexually active participants' patterns of contraception, particularly regarding the birth control pill. At the follow-up assessment, among sexually active teens, participants were significantly more likely than control group members to report that their partner was using oral contraception ($p<.05$), especially if they had not yet had intercourse at the time of the intervention ($p<.01$).

Sexual Impatience

Finally, on measures of sexual impatience, program participants reported greater comfort than did their control group peers with postponing sexual involvement.

Summary

Overall, the single-session intervention, combining a video presentation with a private counseling session, shows promise in promoting support for sexual restraint among abstinent males, and more effective contraception among sexually active youth. Additionally, the field study data provide no evidence that the onset of sexual activity is affected by young men's participation.

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In interpreting the data, the researchers concluded that health care practitioners can play an important role in counseling and educating young men about pregnancy prevention. In addition, based on the finding that the intervention may have resulted in more consistent use of birth control pills by the young men's partners, the researchers emphasized the importance of working with couples. Indeed, they recommended that providers encourage young men who are engaged in unprotected intercourse to return for a visit *with their partners*.

Finally, the researchers acknowledged that their evaluation tested a well-defined *minimal* intervention; future projects should incorporate individualized strategies or follow-up with youth who appear to be at significant risk for unwanted pregnancy or STD/HIV/AIDS. Such strategies might include referrals for additional services at school, by telephone, or in the community, and visits with one's partner. Providers should also develop strategies for serving youth whose cognitive skills are quite limited.

Evaluation Materials for *Reproductive Health Counseling for Young Men*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments*, the *Prevention Minimum Evaluation Data Set (PMEDS)* and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

Included in the *Original Evaluation Instruments* are the questionnaires used in the original field study and evaluation of the *Reproductive Health Counseling for Young Men* program. Separate instruments are included for the pre-test and follow-up assessments. Both surveys probe young men's general health and well-being; feelings about family, peer and intimate relationships; perceptions of peers' risky behaviors; and sexual-related attitudes and behaviors.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Reproductive Health Counseling for Young Men*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

5

School/Community Program for Sexual Risk Reduction among Teens

An Adolescent Pregnancy Prevention Program

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Program Abstract

Title

School/Community Program for Sexual Risk Reduction among Teens

Summary

This program is a community-wide public outreach campaign. It incorporates multiple forms of outreach and public education to engage the entire community in preventing pregnancy among unmarried adolescents. Public schools, universities, church groups and civic organizations are all targeted as sites for training and workshops concerning human physiology, sexual development, self-concept and sexual awareness, values clarification and communication skills. Abstinence is promoted as the preferred sexual health decision in all activities; for teens who do choose to become sexually active, effective contraception is encouraged. The intervention was developed and field tested in a rural, low-income and predominantly African-American community. A significant drop in the pregnancy rate was recorded during the full implementation period of the program.

Focus

☑ Primary pregnancy prevention
☐ Secondary pregnancy prevention
☐ STD/HIV/AIDS prevention

Original Site

☑ School-based
☑ Community-based
☐ Clinic-based

Suitable for Use in

This program is suitable for use in any community in collaboration with a variety of organizations, including schools.

Approach

☑ Abstinence
☑ Behavioral Skills Development
☑ Community Outreach
☑ Contraceptive Access
☑ Contraceptive Education
☑ Life Option Enhancement
☑ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

91

Original Intervention Sample	Age, Gender	Rather than targeting a particular group of teens, the program involved an entire community with a population of 18,796 in 1982.
	Race/ Ethnicity	The community composition was 58% African-American and 42% White.

Program Components

- ☑ Adult Involvement
- ☐ Case Management
- ☑ Group Discussion
- ☑ Lectures
- ☐ Peer Counseling/Instruction
- ☑ Public Service Announcements
- ☑ Role Play
- ☐ Video
- ☑ Other Peer education training program

Program Length

The full program of public service announcements, adult education workshops and graduate courses for teachers may require a full year to implement.

Staffing Requirement/ Training

The project requires a full-time Project Director and an On-Site Coordinator. Both should have a solid knowledge of teen pregnancy and public health strategies.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

Program Rationale and History

The *School/Community Program for Sexual Risk Reduction among Teens* (hereafter referred to as the *School/Community Program*) is a comprehensive, multifaceted approach to public health education. In October, 1982, a field study of the program was initiated in a rural, predominantly African-American and low-income community in South Carolina, where the rate of adolescent pregnancy exceeded the state average. Following the program's success in Bamberg County, a second, sister project was initiated in Hampton County, South Carolina in March, 1992.

Recognizing unintended teenage pregnancy as a major public health concern, the program developers mobilized local residents to participate in a broad-based, community-wide intervention encouraging youth to postpone sexual intercourse. Public schools, universities, church groups and civic organizations all became sites for training, education and workshops. Topics included human physiology and reproduction, sexual development, self-concept and sexual awareness, communication skills and values clarification.

Initial support for the project was obtained through a five-year grant from the US Department of Health and Human Services. Additional funding was provided by the South Carolina State Health and Human Services Finance Commission.

In 1993, the Kansas Health Foundation funded a replication of the program in three Kansas communities.

Theoretical Framework

The program is guided by three theoretical perspectives. They are viewed as complementary ways of understanding individual and community change.

First, the program views sexual risk reduction as an innovation, or a new idea, to be diffused throughout the community. For an innovation to be accepted, it must be perceived as advantageous to the community, consistent with residents' values and needs, easy to understand and carry out, and finally, capable of being tested. Following these principles, in their field study, program staff first aimed to increase knowledge, awareness and commitment among local leaders, who in turn would encourage the larger community to help change adolescents' sexual practices.

Principles of the Health Belief Model suggest that individuals will be likely to engage in health-related behaviors when the following conditions are met:

(1) one perceives that the problem (e.g., teen pregnancy) poses a threat to one's well-being;

(2) one understands the benefits and barriers to taking preventive action; and

(3) one feels able to effectively carry out the recommended actions.

Finally, Bandura's Social Learning Theory elaborates the processes through which intentions can be translated into behavioral change among teens. Bandura asserts that learning occurs through practice and observation of social models; it is mediated by internal beliefs about one's ability to succeed, as well as by others' evaluation of the individual's performance. The *School/Community Program* is designed to expose youth to positive role models, provide opportunities to practice responsible decision making and enhance teens' sense of efficacy over their life circumstances.

Program Objectives

The overall goal of the program is to reduce the occurrence of unintended pregnancy among unmarried adolescents. In the process, the program aims to improve the health and social welfare of the community. Two behavioral objectives are also specified:

(1) to postpone adolescents' initial sexual intercourse; and

(2) for teens who choose to be sexually active, to promote effective use of contraception.

Hypothesized Outcomes

It is hypothesized that an intensive program of school- and community-based education, accompanied by a continuing stream of pregnancy-prevention messages, will be associated with:

- a decrease in unintended adolescent pregnancy in the target community.

In the original field study, the researchers also outlined subcomponents, such as enhancing self-esteem and increasing decision-making skills. However, no specific hypotheses were stated, and these outcomes were not measured in the study.

The original program developers recognized that the success of the intervention would depend on residents' acceptance of adolescent pregnancy as a public health concern, as well as on their willingness to participate in educational activities. In selecting a target community, the developers sought a location with high need (as reflected in an adolescent pregnancy rate above the state average) and a high level of interest. Because many residents of the mixed-race community came from families in which adolescent pregnancy had occurred, perhaps for several generations, program leaders maintained a non-judgmental stance. Instead, they highlighted benefits associated with delayed sexual intercourse, including increased opportunities for education and employment.

Educational Objectives

In the field study of the program, community residents were invited to participate in a continuing program of educational activities. The following objectives, formulated during the original study, are appropriate for participants of all ages:

- to promote the postponement of initial voluntary intercourse as the positive, preferred sexual and health decision for teens;
- to help people recognize that early sexual intercourse and pregnancy can create problems which impair one's quality of life;
- to understand growth and developmental changes experienced by children, adolescents and adults;
- to develop skills in assertiveness, communication, problem solving and decision making that are resistant to peer, social and cultural pressures;
- to enhance the self-esteem and future aspirations of all participants; and
- to understand reproduction and contraception and acquire skills regarding the prevention of pregnancy.

Program Activities

The field study of the *School/Community Program* included the following four concurrent and overlapping outreach activities. However, the components of your intervention may vary with the needs and interests of your community.

(1) **Public awareness**. At the start of the intervention, program staff saturated the community with messages emphasizing both the consequences of adolescent pregnancy and residents' responsibility to help address the problem. The messages included public service announcements on radio, television and in the local newspaper, notes sent from school to parents at home and phone calls from program staff to church representatives.

(2) **Community workshops**. Five workshops addressed parenting skills and social relations between children and adults. These sessions were directed towards ministers, clergy and parents and included sessions on enhancing self-esteem.

communication, responsible decision making and values, as well as reproductive anatomy, physiology and contraception.

(3) **Teacher education**. Public school teachers were invited to participate, at no cost, in three-credit-hour, graduate-level courses at the local university, where they were introduced to principles of family life and sex education. Enrollment for each course was open on a first-come basis to 25 teachers and guidance counselors. All teachers (grades K through 12) were encouraged to apply the material in their classes. Because no specific sex education program was mandated for the county schools, participants integrated units of the Growth and Development Curriculum within their biology, science, social studies and other courses. An outline of the lessons for the curriculum is provided in the next section.

(4) **Peer counselors**. With parental permission, high school students were invited to participate in approximately 70 hours of training. The sessions covered listening, counseling, problem-solving and facilitating skills, along with conflict resolution, understanding human behavior and teen health issues. Each year about 9-12 students completed the program, which was scheduled before and after the school day, as well as on weekends. Trained peer counselors made presentations to middle and elementary school students.

Finally, in conjunction with the *School/Community Program*, school nurses provided family planning education, referrals to public agencies and contraceptive services to sexually active youth.

Program Overview

Public Awareness Activities

Efforts to raise community awareness about the importance of delaying sexual intercourse and pregnancy should occur throughout the duration of your program. Suggestions for working with the media, along the examples from the field study of the *School/Community Program*, are provided in the *Program Handbook*.

Community workshops & Peer Education Training

Listed below are outlines for the community workshops, which, during the field study, were typically held on weeknights from 6:30 to 8:00 PM. A similar curriculum was applied in an expanded format for the peer counselor training sessions.

SESSION 1: Enhancing Self-Esteem

Learning objectives

(1) Participants will assess their personal levels of self-esteem.

(2) Participants will identify psychosocial conditions that influence self-esteem.

(3) Participants will understand basic human needs and wants for a positive self-image.

Content

After a brief introduction, participants review the four conditions of self-esteem (e.g., connectiveness, uniqueness, power, models) and basic needs for a positive self-image. Characteristics of self-accepting individuals are also discussed. The facilitator leads a discussion of strategies for increasing self-esteem among adolescents.

Suggested activities

(1) Participants complete the Rosenberg Self-Esteem Scale for self-assessment.

(2) Participants write brief autobiographies and share them with the group, highlighting their accomplishments and characteristics.

SESSION 2: Communication

Learning objective

(1) This session will teach participants how to differentiate between effective and poor communication. They will demonstrate the skills of attending, understanding, responding and taking responsibility.

Content

Combining a lecture/discussion format, the facilitator illustrates communication strategies that enhance and impede communication.

Suggested activities

(1) Participants give examples of roadblocks to communication and their effects on people.

(2) Participants are video-taped in role-plays, such as parents and teens discussing topics or teens resisting peer pressure in a dating situation. The group critiques the scenes.

SESSION 3: Responsible Decision-Making

Learning objectives

(1) Participants will be able to apply steps in the decision-making process to life situations.

(2) Participants will describe how the decision-making process applies to postponing sexual activity.

Content

After introducing the principles of effective decision making, the facilitator defines each of the steps involved. The importance of careful decision-making concerning sexual activity, contraception and relationships is also discussed.

Suggested activities

(1) Participants identify a problem and carry out the decision-making process, both individually and in a group.

(2) The moderator poses questions for reflection and discussion concerning the decision whether to have sexual intercourse: reasons, consequences, personal values, family and community values, birth control and partner's feelings.

SESSION 4: Values

Learning objectives

(1) Participants will identify and affirm their sexual values.

(2) Participants will be able to apply their values to a life situation.

Content

The facilitator first defines the values-clarification process and then illustrates "the clarifying response," a strategy for encouraging individuals to consider what is most important to them. After considering reasons why teens engage in early sexual activity, the group considers ways adults might assist youth in incorporating values into sexual decision making.

Suggested activities

(1) Participants choose and rank the three most and least desirable factors in a sexual relationship. Working with a partner, participants discuss their choices.

(2) Participants rank order a list of possible lifetime influences on their values (e.g., family members, friends, records, books, movies, church, school). In small groups, participants discuss their top five influences and consider:

—How do these influences affect your values?

—How do you feel about their effects?

—Do you want to change them or are you satisfied?

—How would you like your children to develop their values?

(3) Participants role-play scenarios (e.g., mother/daughter, friend/friend, pastor/parishioner) in which one character seeks the other for advice concerning premarital sex. The "counselor" guides the other person through the valuing process.

SESSION 5: Reproductive Anatomy, Physiology and Contraception

Learning objectives

(1) Participants will be able to describe the fertilization process.

(2) Participants will demonstrate techniques of assertiveness in resisting pressure to have sexual intercourse.

(3) Participants will describe the mechanics and advantages/disadvantages of at least two forms of contraception.

(4) Participants will identify and refute common myths regarding the risks of pregnancy and contraception.

Content

The facilitator introduces key concepts of male and female physiology and sexual development. This is followed by a discussion of contraceptive methods, highlighting abstinence as the most effective form of pregnancy prevention.

Suggested activities

(1) Participants discuss the following:

—What did your parents tell you about sex?

—What are some myths you've heard about sex?

—What do you wish you had been told about sex?

—How do you feel about counseling someone about sexuality?

(2) Participants role-play effective communication in saying "No" to sex.

Ideas for organizing additional educational activities with groups such as Girl Scouts, housing projects and Teens Against Premarital Pregnancy (TAPP), can be found in the *Program Handbook*. Tips are also provided for organizing education sessions with religious organizations.

Teacher Education

Listed below are sample descriptions and recommended textbooks for the graduate-level courses offered to teachers in conjunction with the *School/Community Program*. Sexuality Education, Curriculum Methods and Teaching Methods were the three primary courses; seminars on related topics, such as HIV/AIDS Education and Health Promotion in the Elementary School, were taught as well. Each course included at least 45 hours of instruction and a variety of activities: lecture-discussions, small group discussions, written assignments, demonstrations and curriculum materials evaluations. Strategies for promoting curricular change in family life and sex education can be found in the *Program Handbook*.

HEDU 501: FAMILY LIFE AND SEX EDUCATION PROGRAMS

This course examines problems and questions concerning the inclusion of family life and sex education instruction in health education programs.

Course objectives

(1) To comprehend and internalize the biological, psychological and sociological bases of human sexuality.

(2) To assess the sexual health needs of different populations and construct and coordinate curricula to meet those needs.

(3) To understand and describe the negative consequences of immature sexual activity and promote the value and importance of postponing sexual intercourse among teen populations.

(4) To understand, describe and implement teaching methods that facilitate the learning of basic concepts related to human sexuality.

(5) To justify the inclusion of the study of human sexuality and family life education in various health education settings.

(6) To resolve personal biases and prejudices that may inhibit learning in individual and group interactions.

(7) To achieve personal growth towards attaining a comfortable attitude regarding one's sexual potential.

Text: Bruess, C.E. and Greenberg, J.S. (1988). *Sexuality Education: Theory and Practice, 2nd Edition*. New York: MacMillan Publishing Co.

HEDU R755: SELECTED TOPICS IN HEALTH EDUCATION - IMPLEMENTATION AND METHODOLOGIES IN FAMILY LIFE AND SEX EDUCATION

This course surveys curriculum options, teaching methods and community support strategies for improving family life and sex education instruction.

Course objectives

(1) To assess the curricular options for providing educational programs at specific age and maturation levels.

(2) To acquire planning skills necessary to sequence learning experiences in individual classes and in extended curriculum plans.

(3) To assess the appropriateness of material aids and resources available to supplement instruction.

(4) To understand the purpose of, and acquire the ability to function as, a teacher-facilitator in group settings.

(5) To acquire the skills required to promote appropriate sexual behavior among teens and to promote abstinence as a positive alternative.

Texts: Drolet, J. C. and Clark, K. (eds.) (1994). *The sexuality education challenge: Promoting healthy sexuality in young people*. Santa Cruz, CA: ETR Associates. Brindis, C. D. (1991). *Adolescent pregnancy prevention: A guidebook for communities*. Stanford, CA: Health Promotion Resource Center.

HEDU R729 SELECTED TOPICS IN HEALTH EDUCATION - CURRICULUM PLANNING IN FAMILY LIFE AND SEX EDUCATION

Participants in this course select a curriculum design for their school and integrate curricular objectives, content and learning opportunities into their existing courses.

Course objectives

(1) To review and assess the merits and limitations of family life and sex education curricula currently in use in school districts around the nation.

(2) To select and determine appropriate concepts, objectives, content and learning experiences for one's own school district.

(3) To reach group consensus on strategies for integrating the Growth and Development Curriculum into existing courses.

Texts: Fodor, J.T. Dalis, G.T., and Giarratano, S.C. (1995) *Health Instruction: Theory and Application, 5th Edition*. Baltimore: Williams and Wilkins. Reprints of periodicals and book chapters related to curriculum development. Display of existing family life and sex education curriculum guides.

Student Curriculum

In conjunction with the graduate-level education courses, teachers can implement family life and sex education in their own classrooms. The table that follows lists illustrative program components from the *School/Community Program's* Growth and Development Curriculum used during the field study. For each topic, the grade level and number of sessions are also noted.

GROWTH AND DEVELOPMENT CURRICULUM		
Topic	**Grade Level**	**No. of Sessions**
Self-Awareness, Sex Role	K	4
The Changing Self	K-1	7
Family Relationships	1	4
Self-Concept, Awareness of One's Own and Others' Feelings	2	5
Self-Concept, Getting along with Others	4	4
Socialization, Making Decisions	5	5
Sex Roles in Dating	8-12	4
Saying "No" to Sex	9-10	4
Decision Making and Role-Playing	9-12	6
Male and Female Reproductive Anatomy	9-12	6
The Moral Implications of Abortion: Why not Abortion	9-12	4
Responsible Decision Making, Sexual Development, Family Relationships and Respect for Friends	10	6
Responsible Sexual Decision-Making: Alternatives to Sexual Intercourse	10	3
Intelligent Choice of a Sexual Lifestyle	10-11	5
Saying "No" and Meaning It	11-12	4
Individual/Group Counseling, Decisions	1-12	8

Program Materials: Replicating or Adapting *School/Community Programs for Sexual Risk Among Teens*

Program Handbook

As a collection of public awareness and community education activities, the *School/Community Program* does not include a formal curriculum. In its place the *School/Community Programs for Sexual Risk Among Teens* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of this book. The program contains a handbook, *Implementation Standards and Guidelines for Community-Based Projects: Lessons Learned from the School/Community Sexual Risk Reduction Project* (referred to as the *Program Handbook*). The *Program Handbook* introduces principles of community assessment to assist you and your colleagues in tailoring a program to meet the values and needs of local residents. Additionally, the book offers multiple strategies for collaborating with educators and social and medical service providers to implement community- and school-based activities.

Additional Materials

The need for additional materials will depend on the particular activities you select for your program; for example, if you choose to offer teacher-education courses, textbooks similar to those used in the field study may be adopted (see previous section entitled, "Teacher Education"). A chalkboard, or flipchart and markers, are useful to have on hand for group discussions and workshops.

How to Implement the Program

The *School/Community Program for Sexual Risk Reduction among Teens* requires support and active participation from community residents, civic leaders, church representatives, teachers and educational administrators. For this reason, the program director should begin by reviewing the following four steps involved in Organizing a Community, as outlined in the *Program Handbook* :

Organizing a Community

- Gaining acceptance
- Identifying local needs
- Entering the community
- Establishing trust and support

Following these steps will enable the program director to increase community awareness and build the kinds of partnerships that are necessary to implement a comprehensive, multifaceted intervention.

Evaluating the Program

The Original Evaluation

Initial Design

A matched-area design was used to measure the program's effectiveness. Annual Estimated Pregnancy Rates (EPRs) for adolescent females in the intervention portion of Bamberg County were compared with EPRs in four similar areas. The estimated pregnancy rate is an annual indicator expressing the number of pregnancies that occur per 1,000 females in a population (in this case, per 1,000 females ages 14 through 17 years). The rate is computed as follows:

$$\text{EPR} = \frac{\text{Live Births} + \text{Fetal Deaths} + \text{Induced Abortions}}{\text{Number of Females Ages 14-17}} \times 1{,}000$$

Intervention effectiveness was determined by comparing average estimated pregnancy rates within the target population before and after the intervention, and by comparing the difference between pre-intervention and post-intervention pregnancy rates in populations exposed and not exposed to the program.

The first comparison area was the non-intervention portion of the county. Recognizing that the program may have had some spillover effect beyond the target community, three other South Carolina counties were selected for comparison, based on their sociodemographic similarity to Bamberg County in 1982.

Trends in annual, age-specific EPRs for females ages 14 to 17 years were examined. In addition, average EPRs for a given period was calculated as the sum of annual EPRs for the years included, divided by the number of years in the period.

Average EPRs were analyzed across the four comparison areas for the following periods:

- pre-intervention period (1981-1982)
- post-intervention period (1984-1985)

Evaluation Question

Program evaluators examined whether the target community showed significantly lower rates of adolescent pregnancy, over time, relative to comparable areas of the state.

Where to Get Data

The estimated pregnancy rate for the original field study was devised using annual data supplied by the Office of Vital Records and Public Health Statistics, South Carolina Department of Health and Environmental Control. This agency was able to provide the number of live births, fetal deaths and abortions to South Carolina residents by age of resident, by town and county of resident and by year of occurrence.

The analogous government agencies in your state may be able to provide you with similar data for calculating estimated pregnancy rates in your community for your target population.

Evaluation Results

There was a sharp reduction in the number of adolescent pregnancies in the target community after 1983, when the intervention program had been fully implemented. To illustrate: among 333 female adolescents in the population, ages 14 to 17 years, there were 18 pregnancies in 1981. In both 1984 and 1985, with 319 girls in the population, 8 pregnancies were recorded. During this period there was a slight drop in the number of pregnancies in the non-intervention portion of Bamberg County, and an increase in the other three comparison areas. Simultaneously, population levels dropped in all five areas, with the sharpest declines found in the comparison communities located outside Bamberg County. Focusing on EPRs helps adjust for such fluctuations.

After 1983, the EPR in the target community dropped significantly— from 61.7 in 1983 to 25.1 in 1984 and 1985. This meant nearly 37 fewer pregnancies per 1000 females following the start of the intervention. A less dramatic drop, from 63.1 in 1983, to 58.8 in 1984 and 46.0 in 1985, was measured in the non-intervention portion of the county. In contrast, the pregnancy rates increased somewhat in the three comparison areas outside Bamberg County. For example, in one community, there had been 45.1 pregnancies per 1000 females in 1983; by 1985 the figure had risen to 54.9. Overall, during the post-intervention period (1984-1985), the average EPR for the target community was significantly lower than the average rates in the four comparison groups (p<.01 for all comparisons).

Comparing changes in average EPR between the pre-intervention (1981-1982) and post-intervention (1984-1985) periods, there was a significant drop in the rate measured in the target community (estimated decrease, between 13.7 and 57.3 pregnancies per 1000 females, 95% confidence interval). A smaller, non-significant decrease was found between the two periods for the non-intervention portion of the county. Outside Bamberg County, the average EPR increased significantly in two of the comparison areas, while no significant change was recorded in the other community.

Comparing the rates of change across counties shows that the drop in EPRs between the intervention and non-intervention portions of Bamberg County was not significant. On the other hand, the increase in EPR among the comparison areas did differ significantly from the decrease measured in the target community (p<.002, p<.001 and p<.001 for the three comparisons).

Secondary Analysis

In 1994, the original program developer joined with a team of researchers to re-analyze the program's effectiveness. Three strategies guided the secondary data analysis.

(1) To achieve a closer match between the target and comparison communities, additional sociodemographic data were examined, notably the adolescent pregnancy rate prior to the start of the intervention. A new group of comparison communities was selected for analysis.

(2) The pre- and post-intervention periods were lengthened to allow for an expanded analysis.

(3) EPRs were adjusted to correct for the fact that adolescent females who became pregnant at age 17, but gave birth at age 18, would have been excluded from the original measure.

Across the two evaluation studies, overall trends for the immediate post-intervention period (1984-1985) appeared similar, with a steep, significant decline in EPR recorded in the target community. Yet, the secondary analysis also revealed an increase in the pregnancy rate in 1987-1988, to 66 pregnancies per 1,000 females. By 1987-1988, differences in the adjusted EPRs for the target and comparison communities were insignificant.

After examining possible explanations for the upward trend in EPR, program evaluators focused on significant changes in the scope of program activities. Most importantly, in 1987 public opposition led to the termination of the Teen Life Center's contraceptive services for high school students; in 1988 the nurse who had staffed the center resigned. Thus, in 1987-1988 the county health department clinic was the only family planning service available to adolescents, and it was inaccessible by public transportation. The researchers also noted a decline in enrollment for the graduate-level family life and sex education courses. Overall, they linked the lowest rates of adolescent pregnancy to the years of greatest community involvement (1984-1986); once community support and participation declined, adolescent pregnancy returned to pre-intervention levels. They found additional support for this hypothesis by examining pregnancy prevention activities in the comparison counties. None of these efforts were as comprehensive as the *School/Community Program*, and none of the communities showed a drop in EPR comparable to that measured in the target community during the period of maximum implementation. The secondary analysis confirmed the findings of the original analysis: that the reductions in EPR were due to the intervention.

Summary

There appeared to be a significant decline in the adolescent pregnancy rate in Bamberg County during the full implementation period of the *School/Community Program for Sexual Risk Reduction among Teens*. The program encouraged all community members—including parents, teens, teachers and church representatives— to take responsibility for addressing the problem of unintended pregnancy among unmarried adolescents. In addition to publicizing pregnancy prevention messages in local media, program staff organized workshops for parents and clergy, graduate-level courses for teachers and peer counseling training for youth. The lessons included human physiology and reproduction, sexual awareness and self-concept, communications skills and values clarification.

During the immediate post-intervention period, the target community showed an average decrease of 35.5 pregnancies per 1000 adolescent females. As expected, the intervention showed some spillover into the comparison portion of the county. Still, the average EPR for the target community was significantly lower than that of the comparison area of Bamberg County during the full implementation period. Some of the other comparison counties also showed a drop in EPR, but in all cases the decline in the target community was significantly greater.

However, secondary analysis revealed that in subsequent years, after important elements of the program had been discontinued, the teen pregnancy rate returned to pre-intervention levels in the target community.

Evaluation Materials for *School/Community Programs for Sexual Risk Among Teens*

The original evaluation of the *School/Community Program* was based on changes in the Estimated Pregnancy Rate (EPR), as calculated with data from the Office of Vital Records and Public Health Statistics. Tips and suggestions for conducting this form of evaluation—in addition to the program materials described in an earlier section—can be found in the *Program Handbook* included in the PASHA program package, as noted above. The program package also includes two additional resources for evaluation: the *Prevention Minimum Evaluation Data Set (PMEDS)* and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Measures

Further information on using the Estimated Pregnancy Rate is provided in the *Program Handbook, Implementation Standards and Guidelines for Community-Based Projects: Lessons Learned from the School/Community Sexual Risk Reduction Project*. More detailed information about purposes and levels of program evaluation, with examples from the *School/Community Program*, is provided in the handbook as well.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *School Community Programs for Sexual Risk Among Teens*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

6

School-Linked Reproductive Health Services (The Self Center)

An Adolescent Pregnancy Prevention Program

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Program Abstract

Title

School-Linked Reproductive Health Services (The Self Center)

Summary

Originally launched as a partnership between junior and senior high schools and a neighboring clinic, this program combines education, counseling and reproductive services into a comprehensive intervention. Services are provided by a team of nurses and social workers who divide their time between the schools and the clinic. School-based components include: (1) at least one presentation to each homeroom class per semester to introduce the program and begin discussing values clarification, decision making and reproductive health; (2) informal discussion groups that arise as students seek advice and information from staff on such themes as pubertal development, drug use and parenting; and (3) individual counseling sessions, available as needed, with a social worker. At the clinic, reproductive health and extended counseling services are provided, and referrals are given for teens requiring medical care. In addition, clinic staff encourage students to participate in discussion groups and examine educational videos and pamphlets. Although the intervention was launched as a primary prevention effort, secondary prevention might be incorporated, as well.

A three-year field test of the program was conducted in a low-income neighborhood in Baltimore, MD, where elevated rates of sexual activity and teen pregnancy had been recorded. Compared to their peers attending comparable schools, students in program schools showed reduced levels of sexual activity and more effective use of contraception; the effects were greatest among younger girls and boys whose use of contraception was minimal at the start of the program. A delay in the onset of sexual activity was also recorded among youth who were abstinent at the start of the program.

Focus	☑ Primary pregnancy prevention	☐ Secondary pregnancy prevention	☐ STD/HIV/AIDS prevention
Original Site	☑ School-based	☐ Community-based	☑ Clinic-based

Suitable for Use in	This program can be implemented either with school-clinic or community-clinic partnerships. The clinic should be located in close proximity to participating schools or community organizations, or easily accessible to teens.

Approach

- ☑ Abstinence
- ☑ Behavioral Skills Development
- ☐ Community Outreach
- ☑ Contraceptive Access
- ☑ Contraceptive Education
- ☐ Life Option Enhancement
- ☐ Self-Efficacy/Self-Esteem
- ☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age	The program was intended to serve all students enrolled in two urban schools, one junior high and one senior high (approximately 1,700 students total). Nearly all students regularly attending school were exposed to at least one program component.
Race/ Ethnicity	100% African-American

Program Components

- ☐ Adult Involvement
- ☑ Case Management
- ☑ Group Discussion
- ☑ Lectures
- ☐ Peer Counseling/Instruction
- ☐ Public Service Announcements
- ☐ Role Play
- ☑ Video
- ☑ Other team of student assistants and outreach workers; informal education and games

Program Length

The school-based components of the program operate continuously during the academic year. The program nurse visits each homeroom class at least once each semester, and all program staff are available to students for individual counseling or informal group discussions during lunch/free periods. The clinic services are available to teens year round—on weekday afternoons and during school vacations.

Staffing Requirements/ Training

One social worker and one registered nurse (either a nurse practitioner or nurse midwife) are required for each participating school or community organization. (Note: this was the arrangement followed during the original field study—your needs may depend on the size of the school(s) or organization(s) you plan to serve.) A program administrator, preferably with training in the field of education or health education, is needed for each clinic site. Other professionals (e.g., physicians) should be on call to provide necessary services and supervision.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

School-Linked Reproductive Health Services (The Self Center) combines educational, counseling and reproductive health services in an effort to reduce unintended pregnancy among junior and senior high school students. Services are provided through a collaboration between schools and nearby school-affiliated clinics. The program consists of both in-school and clinic components, which are delivered by a shared staff of nurse educators, counselors and on-call physicians.

The Self Center was originally conducted as a demonstration project by the Johns Hopkins School of Medicine and the Baltimore City Departments of Education and Health. The program was implemented and field tested between 1981 and 1984 at a junior and senior high school located in an urban, low income neighborhood in Baltimore, Maryland. All students at the program schools were African-American.

During the study period, students had access to program services at both school sites, as well as at a nearby clinic. Education and counseling services were provided by teams of health and social work professionals. In-class presentations, small group discussions and individual counseling were offered in schools, and peer groups and group and individual counseling were provided in the clinic. Contraceptive and other reproductive health services (such as pregnancy testing and treatment for sexually transmitted diseases) were also provided, free of charge, in the clinic.

Funding for the demonstration project was provided by the Educational Foundation of America, the Ford Foundation, the W.T. Grant Foundation, the Hewlett Foundation, the Charles Stewart Mott Foundation and the Jessie Smith Noyes Foundation.

Theoretical Framework

This program is rooted in the idea that improving teens' access to reproductive health-related education and medical services will reduce unintended pregnancy. A number of factors, including lack of transportation, difficulty planning ahead for appointments, concerns about confidentiality and limited financial resources, make negotiating the health care system daunting for many teens. The original program developers saw schools as an ideal place to make first contact with students and to provide a bridge to clinic services. As such, they designed an integrated program linking two schools and a nearby clinic in providing education, guidance and reproductive health services.

In addition to enhancing contraceptive access, *The Self Center* focuses on helping teens recognize the impact of their behavior on their capability to realize personal, social and educational goals. For this reason, the program aims to: (1) help teens to understand how sex, unintended pregnancy and premature parenthood can affect their ability to meet personal goals and (2) empower teens to make responsible decisions. This approach is represented by the program's motto, "Make a life for yourself before you make another life." In the original field study, this motto was displayed on program stationery and frequently cited in education and counseling sessions.

It is important to note that the original field study of *The Self Center* was able to provide students with confidential reproductive health services because state law in Maryland allowed minors to receive birth control supplies and information without parental notification or consent. In addition, it should be noted that *The Self Center* activities and services were not implemented as a stand-alone curriculum, but in addition to the existing state-mandated sex education curriculum provided at Maryland junior and senior high schools.

113

Program Objectives

The overall goal of *The Self Center* is to reduce the incidence of unintended pregnancy among junior and senior high school students. Specifically, the program endeavors to:

(1) increase students' knowledge of physical maturation, human sexuality, contraception, fertility and awareness of the personal burdens and costs of unintended pregnancy;

(2) reinforce positive attitudes toward pregnancy prevention and promote realistic attitudes toward premature pregnancy and parenthood;

(3) postpone first intercourse among adolescents who are not yet sexually active;

(4) increase the use of professional contraceptive services by adolescents who are sexually active;

(5) increase the use of effective contraception by adolescents who are sexually active; and

(6) reduce the rates of adolescent pregnancy, abortion and childbearing.

Program Outline

The Self Center consists of six categories of services—three of which are delivered in school and three of which are delivered in a nearby clinic. The program staffing, overall educational approach and basic structure of these components (as implemented in the field study) are described briefly below.

Please note that this information is provided as a model, based on the original study. Particular components may need to be altered to fit the needs of your teens and the values of your schools and community. Additional details and recommendations for organizing and implementing the program are outlined in the *Program Manual* that is included in *The Self Center* program package (see Program Materials section below).

Educational Approach

The major thrust of the educational component of the program is to encourage personal responsibility and goal-setting so that students will postpone sexual activity until they are more mature. Although abstinence is emphasized as the most effective means of pregnancy prevention, the need for effective contraception for those who choose to be sexually active is also explicitly recognized. For this reason, educational activities are designed to help students understand: (1) the risks of pregnancy and STDs following unprotected intercourse; (2) the reproductive process, including contraceptive methods and their relative effectiveness and safety; and (3) the potentially adverse consequences of unintended pregnancy for teens' future lives.

Program staff should be particularly sensitive to the special emotional and educational needs of young people. Interactive, rather than didactic, presentations are preferable for all but the classroom presentations. In addition, the clinic waiting room can provide students with informal educational resources, such as videos, games, posters and pamphlets on issues regarding sexuality and health. An important tenet of the program is that teens need to be oriented to their future lives and receive consistent and frequent expressions of expectations for success. In the field study, for example, program staff posted information about community events, local colleges and training programs, along with other optimistic messages in addition to the more traditional "warnings" about adolescent sexual involvement.

Program Staff

The core service staff for each participating school is a team comprised of a social worker and registered nurse (RN). In the original field study, each of the two social workers was paired with a nurse-midwife or a pediatric nurse practitioner. These teams delivered the bulk of services provided to students. All program staff were selected for their experience and interest in working with adolescents.

Program teams visited the participating schools each morning and became acquainted with students by giving at least one classroom presentation per semester. Team members were also available in the schools' health offices during students' lunch and free periods for individual consultation or small group counseling work. The same social worker-nurse teams were available to students in a nearby clinic later in the afternoon. Additional clinic staff included a clinic administrator/educator, a receptionist, a nurse's aide and a supervising physician.

The original implementation of *The Self Center* also employed a peer resource team of twelve students, who were trained to serve as representatives of, and spokespersons for, the program. These students wore T-shirts and/or buttons that read, "Ask me about *The Self Center*," and assisted with tasks such as distributing handouts and talking with drop-in students when staff members were involved in individual counseling sessions.

In-School Services

In-school components of *The Self Center* program are designed to reach junior and senior high school students and to serve four basic functions: (1) to provide instruction in each classroom at least once, and usually more often, during each semester; (2) to serve as a resource for teachers in their routine health and sex education programs; (3) to offer individual and/or small group counseling as needed and/or answer student questions; and (4) to bridge the school and clinic components of the program.

Classroom Presentations

In the field study of the program, staff gave one hour-long presentation to each homeroom class per semester. The presentations were designed to introduce students to the program's services and provide educational information on various topics concerning reproductive health. In addition, program staff were available to offer additional class sessions on related topics by request, and to serve as a resource for the school's regular health education program.

Group Discussions

In addition to classroom presentations, the program social worker at each school was available mid-day during students' lunch or free periods. During these times, students dropped by to ask questions or take advantage of the variety of informal educational materials available in the health offices. The health offices were the site of frequent, spontaneous small-group discussions, ranging from informal "rap sessions" to more focused discussions of problems identified by students or program staff. Moreover, staff used the informal discussions to identify students whose emotional needs warranted additional counseling within the program or with outside agencies.

Individual Counseling

Individual counseling services were available to students during the school day. Program social workers publicized the hours they were available for private consultation. Students sought out program staff to discuss personal issues, such as relationships with the opposite sex, problems at home, pregnancy scares and other confidential matters. Because the academic setting did not allow for prolonged consultations or great privacy, additional, longer-term counseling was also provided at the afternoon clinic.

Clinic Services

In the original field study, *The Self Center* clinic services were provided at a store-front clinic located across from one school and four blocks from the other. The clinic operated in the hours after school. In addition to nurse-counselor teams who moved to the clinic in the afternoon, clinic activities were directed by a clinic administrator, who was a trained health educator. Contraceptive and other reproductive health services (such as pregnancy testing and treatment for sexually transmitted diseases) were provided to students at no charge. In addition to reproductive health care, group education and individual counseling were also provided.

Reproductive Health Services

The Self Center clinic provided students in program schools with reproductive health and contraceptive services. Students could obtain condoms, spermicide and oral contraceptives. In addition, students could receive care for a variety of sexuality-related problems, including menstrual irregularity, growth and development problems, sexually transmitted disease concerns, pregnancy tests and birth control concerns. Females seeking oral contraceptives were given a physical exam and counseling in the use of this method. Although the nursing staff served as the primary contacts for students' health concerns, a physician (gynecologist) was also available for consultation and supervision. Clinic staff provided referrals for medical problems other than reproductive health concerns.

Group Education

During the original field study, the clinic waiting room served as a center for informal education through audiovisual resources, games and small group encounters. More formal educational sessions were guided by a health educator. Clinic staff were available in the waiting room. Some of the educational sessions were organized around specific topics (proposed by students as well as staff), while others arose from student discussion of personal experiences or concerns. Informal discussions often led to larger group discussions which then took place in the "Rap Room." Clinic discussion groups and presentations were held on all but one day a week, which was reserved for first-time clinic patients. First-time visitors received a special orientation that welcomed them to the clinic and praised them for being sexually responsible.

Individual Counseling

One of the main services provided by the clinic was individual counseling. Although counseling in a school setting is somewhat more accessible to students, clinic counseling is not restricted by rigid schedules, so teens can have longer, regularly-scheduled counseling sessions. In the field study of the program, students who sought condoms or other birth control methods were required to register for and participate in an initial psychosocial interview. Often the interview would reveal areas warranting further exploration through counseling. During the original study, staff provided counseling on a broad range of issues, including pubertal development, relationships and family problems. Few limits were placed on the amount of counseling students could receive.

Program Materials: Replicating or Adapting *School Linked Reproductive Health Services (The Self Center)*

The *School Linked Reproductive Health Services (The Self Center)* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of this book. The program package provides a model for implementing *The Self Center* program. In particular, the *Program Manual* will equip you with the information necessary to organize and implement the program in your school and community.

The specific program materials (e.g. games, pamphlets, videos) that will be available to students at participating sites should be chosen with your staff and teens in mind. Choose materials that reflect students' needs and concerns, and are appropriate to their reading levels and primary languages. There are several organizations that supply quality educational materials for teens on issues of health and sexuality. Sample brochures and pamphlets, as well as publishers' catalogs, are included in the PASHA program package. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

How to Implement the Program

There are a number of issues to take into account when attempting to implement *The Self Center* or a similar comprehensive pregnancy prevention program. Detailed recommendations for implementing *The Self Center* program are provided in the accompanying *Program Manual*. A brief overview of some of the major issues is provided below.

Confidential Reproductive Health Care for Minors

This program was originally implemented in a state where reproductive-related health care and contraceptives could be provided to teens without parental consent; however, your state laws may limit the ability of your staff to provide confidential care and contraceptive access to minors.

An Adjunct Sexuality Curriculum

In the original field study, *The Self Center* program did not serve as a stand-alone sexuality education curriculum. Instead, program services were delivered in addition to state-mandated sex education. Moreover, staff members often collaborated with school health educators to assist in delivering the required curriculum.

School and Community Support

School and community support are imperative to the success of any program like *The Self Center*. Suggestions for enlisting the support of teachers, parents and other community members are provided in the accompanying *Program Manual*.

Staff Skills

Staff who are knowledgeable and capable of communicating well with students are needed to make this program successful. Because informal discussions help to identify educational and counseling issues, as well as to build student trust and rapport, staff need to be skilled in small group processes. During the field study, students reported that *Self Center* staff really cared about them; this perception helped them feel comfortable using program services.

Evaluating the Program

The Original Evaluation

Design

The original evaluation of *The Self Center* investigated the impact of the intervention on students' fertility-related knowledge, attitudes and behavior. The researchers followed two analytic strategies. Using a matched-comparison design, they compared teens in participating schools with youth attending schools with similar social and demographic characteristics. Additionally, using a pre/post-test design, they investigated changes within program school students over the course of the study. Self-administered questionnaires were given to teens at the following points:

Time 1: fall, 1981, prior to the start of the program (all schools);

Time 2: spring, 1982, the end of the first program year (program schools only);

Time 3: spring, 1983, the end of the second program year (program schools only); and

Time 4: spring, 1984, the end of the final program year (all schools).

The questionnaires measured students' knowledge regarding sexual health and birth control, attitudes toward teen pregnancy and parenting, sexual history, use of birth control and any pregnancies experienced. Additionally, the evaluators collected detailed information on program participation through staff-maintained records and student sign-in sheets. An examination of financial records also allowed for an assessment of the relative costs of various program components.

Design Issues

The program was designed, in part, to test the belief that school-linked programs like *The Self Center* can reach young people who otherwise would not be served by professional health facilities. If this assertion were true, program evaluators felt that the impact of the program should be evident among the entire student body in participating schools— not merely among the subset of teens who attended the clinic. Consequently, teens not attending the clinic might be likely to seek similar services in other settings, as well. Therefore, the field study of *The Self Center* program was designed to assess changes in the knowledge, attitudes and behaviors among *all* students who attended program schools during the time *The Self Center* was in place, rather than only those students who took advantage of various program services.

Moreover, the original evaluators cited and addressed a number of methodological problems that are unique to program evaluations conducted in a school context; these concerns are discussed briefly below and elaborated in the book, *Evaluation of Pregnancy Prevention Programs in the School Context*, that is included in the previously described *Self Center* program package. Should you choose to evaluate your implementation, take care to consider these issues—or seek assistance from an evaluation consultant.

Student Mobility. Student mobility into and out of individual schools (due to graduation, moving or transfer) makes it difficult to identify a fixed population in which behavioral change or the use of particular services can be measured. In statistical terms, it becomes difficult to determine the denominator in calculating the ratio of particular behaviors to a given population, particularly when program effects on the entire student body are used as the key measure of program impact.

Comparability of Program and Control Schools. It is difficult to locate comparable schools to serve as program and comparison/control sites. Schools that appear similar may have important differences that are likely to affect the detection of program outcomes. The original evaluators felt that it was more appropriate to use data from the two control schools to establish the presence or absence of change in the absence of the intervention, rather than to compare absolute rates or numbers between the program and control schools at specific points in time.

Attrition among High-Risk Students. Schools where the need for pregnancy prevention or other special programs is greatest may also have higher than average transience rates and large populations of chronic absentees and/or dropouts. This issue complicates the measurement of program effects, since students who receive program services may not be in attendance when follow-up assessments are administered. In the original field study, data from the comparison schools were used to control for the fact that spring semester drop-outs and/or transience might exclude less motivated or at-risk students from the sample.

Age, Grades and Program Exposure. Once a program serving multiple grades of students has been in place for several years, older students have had a greater opportunity for longer exposure to the intervention. Data collection and analysis plans must take this factor into consideration. The original field study of *The Self Center* classified students both by their grade level and years of actual exposure to the program. Life table analysis—a statistical method used to determine the probability of an event, such as conception or first intercourse, occurring by a specific age or time—was used to determine specific program effects.

Evaluation Questions

The original field study was designed to address the following questions.

(1) Will students at program schools exhibit greater improvement in knowledge of reproductive health, contraception and the consequences of adolescent parenthood following exposure to *The Self Center?*

(2) Will students at program schools show improved attitudes toward pregnancy prevention and more realistic beliefs about premature conception and parenthood following exposure to *The Self Center?*

(3) Will non-sexually active students at program schools postpone the initiation of sexual intercourse until a later age following exposure to *The Self Center*?

(4) Will students at program schools increase their use of clinic services following exposure to *The Self Center*?

(5) Will sexually active students at program schools demonstrate more effective contraceptive use following exposure to *The Self Center*?

(6) Will students at program schools exhibit lower rates of pregnancy, abortion and childbearing following exposure to *The Self Center*?

Data Collection Procedures

A few days before each survey was to be administered, parents were mailed written notification about the study, along with an explanation of the need for students to complete sensitive, anonymous questionnaires. Parents were assured that they could withhold consent for their child's participation in the study, and they were provided with a telephone number to call if they had further questions or wished to have their child excused. Only two parents withheld consent, though several called to ask questions or express support for the program. Prior to distributing the questionnaires, homeroom teachers provided students with an additional opportunity to decline to participate; however, very few students refused to complete the surveys.

Questionnaires were distributed to classroom teachers in packets. Teachers were responsible for returning every questionnaire, even those that remained blank. All packets were assigned six-digit classroom identification numbers but were not labeled with individual identifiers.

Because the surveys were completely anonymous, they yielded cross-sectional, rather than longitudinal data. That is, the analysis considered the entire group of respondents at each assessment period, rather than following the behaviors of individual students over time.

Research Sample

Baseline questionnaires were completed by 667 males and 1,033 females at the two program schools (representing 98% of the junior and senior high students who attended school on the day the Time 1 survey was administered). All students at the program schools were African-American. Follow-up surveys were administered each spring over the three year period of the study. Lower school enrollment and attendance during the spring yielded smaller research samples. Thus, the Time 2 assessment included 498 male and 793 female students, the Time 3 assessment, 450 male and

764 female students, and the final, Time 4 assessment, 506 males and 695 females. Refusal rates for follow-up at the program schools ranged between 2-3%.

The comparison group sample was also drawn from two urban schools. Unlike the program schools, comparison schools were racially mixed. However, only data from the 944 male and 1,002 female African-American students who completed the Time 1 survey, and the 860 male and 889 female African-American students who completed the Time 4 follow-up, were used for the analysis.

Service Logs

Student contacts with program staff and services were well documented. In particular, the staff maintained daily logs of student contacts (both at school and in the clinic). In addition, the clinic had sign-in sheets in the waiting room, and program staff completed registration forms for students seeking individual services and medical history forms for students receiving care from a nurse or physician.

Evaluation Results

The field study showed that *The Self Center* was particularly effective in changing students' fertility-related knowledge and behaviors. The impact on attitudes was less striking, because participants' attitudes were already quite positive when the program began. These findings are elaborated below.

Knowledge and Attitudes

At the start of the study, students in program and comparison schools scored similarly on the ten-item knowledge test. At the Time 1 assessment, females answered 6.8 questions correctly. After two years of program exposure, the average number of correct responses rose to 7.8, and males showed similar, significant increases. In contrast, no significant changes were recorded in the scores of students attending comparison schools.

Program evaluators also assessed changes in students' attitudes regarding: (1) the acceptability of teenage pregnancy; (2) the ideal ages at which to marry and have children; and (3) the acceptability of intercourse between persons who have just met or who date occasionally. In contrast to the changes in knowledge, the researchers found that these three attitudes were not consistently affected by program exposure. For example, although positive support for adolescent childbearing declined among program females, there was no consistent program effect for males. Similarly, at the start of the study, a large proportion of students reported ideal ages for childbearing that were lower than those considered ideal for marriage. Following the program, these percentages declined for girls but not for boys. Within the comparison schools, no change was found. With respect to attitudes toward "casual sex," evaluators observed no consistent change in program schools and a statistically non-significant decline in the comparison schools.

In interpreting these findings, the evaluators noted that the majority of students held rather positive attitudes toward contraception and rather negative attitudes toward adolescent childbearing and casual sex before the program began. Consequently, significant change in these outcomes would be difficult to detect.

Sexual and Contraceptive Behaviors

At the start of the study, the researchers measured high levels of sexual activity in both program and control schools. Over 90% of all junior and senior high males, over 50% of junior high females, and nearly 80% of senior high females reported that they were sexually active. Although large percentages of students (71% of sexually active junior high students and 89% of sexually active senior high students) reported having used a family planning method at some time, far fewer reported using a method at last intercourse. Furthermore, over 10% of sexually active junior high and over 22% of senior high girls had already experienced a pregnancy when the Time 1 data were collected.

Onset of Sexual Activity

The researchers investigated the timing of first coitus among program students only. At the follow-up assessments, they found that students who attended program schools during the entire three-year study period postponed intercourse for an average of seven months. Smaller delays were evident for students who had only one or two years of program exposure. Furthermore, there was a two-thirds reduction in the proportion of girls attending program schools who became sexually active by ages 14 or 15, a time of great risk for unintended pregnancy.

Clinic Attendance

Clinic attendance increased dramatically among program school students following exposure to *The Self Center's* services. When the program began, only 49% of the sexually active female students and 16% of the sexually active male students had visited a clinic for contraceptive assistance. After one year of exposure to the program, 63% of sexually active females and 28% of sexually active males had sought professional contraceptive services. After three years' exposure, 71% of females and 48% of the males had used clinic services. No such increase in clinic attendance was observed in the comparison schools.

In addition to increasing the *frequency* of clinic attendance, *The Self Center* improved the *timeliness* of clinic visits. Over the course of the study period, significantly more students in program schools attended the clinic within the first three months of initiating sexual activity, as compared to their peers attending comparison schools. Furthermore, an increased number of program students sought professional advice on birth control *prior* to having intercourse for the first time after exposure to the program. In the comparison schools, in contrast, the researchers found no consistent changes in teens' use of reproductive health clinic services.

Contraceptive Use

At the Time 1 assessment, nearly 57% of sexually active females and 49% of sexually active males reported using contraception at their last sexual intercourse. After two years exposure to the program, the proportion of students who reported using some method of birth control at their last sexual encounter rose to nearly 77% among sexually active females and almost 56% among sexually active males. In addition, the percentage of females using oral contraceptives increased significantly among all grade levels, particularly among younger girls, following exposure to the program. Unprotected intercourse also dropped to extremely low levels. In all but one subgroup of one grade, fewer than 20% of females who had been exposed to two or more years of the program failed to use any contraceptive method at last intercourse. In contrast, in three grades at the comparison schools, 45-50% of students reported using no method of birth control at all.

Condom use did not change consistently as a result of program exposure. Instead, it appeared to fluctuate with the use of female contraceptive methods. This is not surprising given that condom use as protection against HIV infection or other sexually transmitted diseases (as distinct from pregnancy prevention) was not stressed in the original implementation of *The Self Center*.

Pregnancy Rates

The evaluators used life table analysis to estimate the cumulative percentage of sexually active students in grades 9-12 who became pregnant at different points during the study period. However, seventh and eighth grade students were not included in this analysis due to the small number of pregnancies and less detailed pregnancy information collected for this group of students.

Program and control schools showed similar pregnancy rates at the Time 1 assessment. However, at 16 months into the program, pregnancy rates at the comparison schools had increased by 50%, reflecting increased rates in the city of Baltimore during this time. At 28 months into the project, the pregnancy rates had increased by 58%. In contrast, after an initial increase of 13%, the pregnancy rates decreased in the program schools. In particular, there was a 22% drop for students exposed to the program for 20 months and a 30% drop for students exposed to the program for the full 28-month program period. Consequently, by the end of the study period, the pregnancy rates in program and control schools differed by nearly 90%. Using mathematical models, the evaluators concluded that the reductions were due (in equal part) to a decrease in the frequency of intercourse and an increase in the use of effective contraceptives. Additionally, abortion and childbearing rates also dropped in program schools over the course of the field study.

Patterns of Service Utilization

Detailed analyses of the teens' service utilization revealed that 85% of all students enrolled in participating schools were exposed to at least one program component. When adjusted for chronic absenteeism, it still appeared that even chronic absentees were occasionally reached by some aspect of the program. At the same time, the researchers found that nearly all students who regularly *attended* school had at least one contact with *Self Center* activities.

Sixty eight percent of all student contacts with program staff took place in the school setting. Approximately 73% of program school students (96% if estimates are based on those in regular attendance) heard at least one classroom presentation. The popularity of spontaneous in-school discussions or "rap sessions" is evidenced by the participation of over 50% of all students in these discussions and the fact that they accounted for more than 40% of all student-staff interactions. Fifteen percent of students took part in individual counseling in school, and a slightly higher percentage received such counseling at the clinic. Although over one-quarter of students enrolled at the program schools participated in group education at the clinic, relatively few students attended group sessions unless they also came for some other clinic service.

Finally, nearly 15% of those enrolled in program schools made reproductive health-related medical visits. An examination of students' routes to the clinic supported the hypothesis that the school was a good base from which to encourage clinic attendance. For the vast majority of patients (88%), school contact with program staff preceded their first clinic visit.

The evaluators also considered gender differences in the teens' use of program services. They found that females generally used many more medical, clinic group education, and individual counseling services than did males. However, among junior high school students, males and females used clinic group education and clinic counseling services at comparable rates. The staff also reported that a few students—among the most difficult and needy cases—required inordinate amounts of staff time.

Cost Analyses

The program evaluators examined financial records to determine the costs associated with various of *The Self Center* components. Because *The Self Center* was a comprehensive and multifaceted intervention, the overall costs of the program were high. However, the evaluators concluded that *Self Center* services could be delivered for less money. The relative costs and effectiveness of program components are outlined below.

Approximately 40% of the total budget was directed toward the school-based components, while 60% went toward the clinic components. The average cost per student served was $122. However, when analyzed by gender, services to females were approximately four times as costly as services provided to males. When analyzed by school level, services for senior high students cost more than double those provided to junior high students. These differences are due in part to the fact that females in general, and senior high females in particular, took part in many medical and counseling services.

One surprising finding was that costs for counseling exceeded those for medical visits. This was attributed to the amount of time social workers spent in individual counseling sessions. Staff members felt it would be difficult to set limits on the amount of counseling provided and still meet student needs. Indeed, they wondered whether this strategy might only increase the number of questions and concerns addressed to physicians and nurses, whose hourly costs were equal to or greater than those of the social workers.

The small group sessions conducted by social workers in the school attracted large numbers of students, many of whom would not have been reached if services were only offered at the off-campus clinic. This service proved to be extremely cost-effective, with per student costs well below those of classroom presentations. Although classroom presentations involved many more students at a given time, each one required an entire class period to deliver, as well as advance preparation by program staff.

The use of peer resource teams, while gratifying to the students who staffed them, did not appear to contribute to program success. Instead, paid students consumed both staff time and financial resources. Few students at program schools reported that the peer teams influenced their use of program services.

The researchers asserted that cost analyses are primarily useful for estimating maximum program costs and understanding the relative costs of various components. In fact, they conceded that *The Self Center* staffing had been relatively luxurious and that the program could be implemented for less. Specifically, program costs might be reduced with the following modifications:

- limiting school-based staff to a program social worker (rather than both a nurse and social worker);
- sharing program staff among participating schools; and
- relying on small, in-school discussion groups to disseminate program information and provide a bridge to clinic services.

Summary

In summary, *The Self Center* showed multiple, positive impacts on students' reproductive health-related knowledge and behaviors. To begin, exposure to the program delayed the onset of sexual activity among teens who were abstinent at the start of the study; it was also associated with a reduction in the frequency of intercourse among sexually active students. Additionally, students who continued to have intercourse used effective methods of birth control following program exposure. Timely clinic attendance also improved among program school students, as reflected in a greater number of clinic visits and earlier clinic attendance following (and in some cases, preceding) the initiation of sexual intercourse. Effective contraceptive use and decreased frequency of intercourse led to a drop in the pregnancy rates among students at program schools, while the rates at comparison schools increased. The field study further demonstrated that abortion and pregnancy rates could be reduced *and* sexual onset postponed by the same program. These findings refute the hypothesis that providing teens with contraceptive services or discussing the responsibilities of sexual intercourse will promote increased sexual activity.

The way in which students used the school components as a bridge to the clinic suggests that a visible relationship between the school and the clinic is crucial to program success. In fact, 88% of students who attended the clinic made their first program contact in school. Although the program was costly in terms of staff time, program evaluators felt that the costs were clearly warranted by the savings from unintentional pregnancy, abortions and births avoided. Nevertheless, program developers and evaluators suggest a number of ways in which program costs might be reduced in the future.

High rates of HIV and other STD infection among teens make it imperative that any future implementation of *The Self Center* address HIV-related risk and prevention behaviors in addition to pregnancy prevention. Promotion of abstinence and safer sex, along with the proper and consistent use of condoms for STD protection, should be emphasized in all program components.

Evaluation Materials for *School Linked Reproductive Health Services (The Self Center)*

In addition to the program materials described in an earlier section, the PASHA program package includes several resources for evaluation: the questionnaires used in the original evaluation; sample Parental Notification Forms; a textbook describing the research design and important methodological issues; the *Prevention Minimum Evaluation Data Set (PMEDS);* and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

The Original Evaluation Instruments

The surveys used in evaluating the effectiveness of *The Self Center* ask students for detailed information on their knowledge, attitudes and behavior regarding sexual conduct, contraception and teenage pregnancy and parenthood. Additional items solicit information about students' relationships with their parents and partners, educational aspirations and a range of background and demographic variables (e.g., age, date of birth, race, number of years in school, etc.).

Six alternate types are provided (for male versus female students, for younger versus older students and for different half-samples of older students). In the original field study, Types 1 and 2 were administered to 9th through 12th grade males, Types 3 and 4 to 9th through 12th grade females, Type 5 to 7th and 8th grade males, and Type 6 to 7th and 8th grade females. The different questionnaire types were color-coded to make it easier for teachers to distribute correct forms to the appropriate students.

In order to maximize the number of questions that could be asked in the time available, the original evaluators employed split samples of 9th through 12th grade students. Questionnaires completed by each half-sample (i.e., Types 1-4) contained a small proportion of unique items. In addition, questionnaires completed by 7th and 8th grade students (i.e., Types 5 and 6) were slightly shorter than those completed by older students. Although the basic content of questionnaires remained the same, some changes in actual content were made across the various rounds of data collection. Questionnaires used in the comparison schools were analogous to those used in the program schools with the exception that items dealing directly with use of *The Self Center* services were omitted.

Also included in the evaluation packet are supplemental questions that were used during the follow-up assessments with program participants. You may want to incorporate these measures into your own evaluation. However, you will find that some items contain information specific to the original field study; make sure to review carefully and change the wording to fit your own intervention.

Finally, it is important to note that the surveys do *not* address several variables related to the transmission of the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). You may wish to consider adding relevant measures (e.g., sexual orientation, drug use and same sex contact) in your own evaluation. These questions, though sensitive, would permit greater exploration of the risks of HIV infection in adolescent populations.

Parental Notification Form

The original evaluators mailed this form to the parents of all students in *The Self Center* schools. The form is designed to build support for the program and inform parents about the evaluation questionnaires that would be given to their children. In the original field study, parents were provided with a telephone number that they could call to discuss with the researchers any comments or concerns about their child's participation.

Data Logs

In addition to the student questionnaires, the original team of evaluators used student sign-in sheets and daily staff logs to monitor students' use of program services. If you choose to implement and evaluate *The Self Center*, you might employ similar methods, or create alternative means to monitor program usage, such as bar-coded identification cards or computer log-ins.

Evaluation Textbook

The PASHA program package also includes a book describing the researchers' original evaluation methodology in greater detail: *Evaluation of Pregnancy Prevention Programs in the School Context*. The text addresses such topics as collecting data, defining a research sample and constructing a survey instrument. It is recommended that you review this book if you choose to replicate and re-evaluate *The Self Center*.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *The Self Center*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

7

Tailoring Family Planning Services to the Special Needs of Adolescents: New Adolescent Approach Protocols

An Adolescent Pregnancy Prevention Program

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Program Abstract

Title

Tailoring Family Planning Services to the Special Needs of Adolescents: New Adolescent Approach Protocols

Summary

This family planning clinic-based intervention was originally developed for teens less than 18 years of age. It is based on the premise that regular contraceptive use by sexually active teens can be increased by offering information, social support and counseling, in addition to health and medical services. Accordingly, the program aims to provide family planning services in a manner that will increase teens' sense of comfort, increase their self-confidence, and reduce any fears that may discourage regular and effective contraception. A key component of the intervention is the Personal Information Form, a one-page questionnaire designed to aid staff in understanding teens' concerns, providing counsel and identifying patients who may be at greatest risk for early pregnancy. To ease teens' anxiety, the first appointment is divided into two visits, with education and counseling provided in the first session and the medical examination (and contraceptive prescription) deferred until the second. The intervention also includes: (1) counseling and education in a one-on-one rather than a group setting; (2) use of visual aids; (3) a follow-up visit scheduled six weeks after the initial appointment; and (4) encouragement of participation by family members, partners and friends, while respecting the patient's right to confidential services.

A field study was conducted with 1,261 teens attending six family planning clinics. Compared to their peers receiving standard services, program participants showed significantly greater gains in knowledge and contraceptive use at the 6- and 12-month follow-up assessments. Participants also experienced significantly fewer pregnancies over the following year than their comparison group peers.

Focus

☑ Primary pregnancy prevention

☐ Secondary pregnancy prevention

☐ STD/HIV/AIDS prevention

Original Site

☐ School-based ☐ Community-based ☑ Clinic-based

Suitable for Use In

This program is suitable for use in community-, hospital- or school-based family planning clinics.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☑ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☐ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age, Gender	The field study involved 1,261 adolescent females, of whom 40% were age 17, 34% age 16 and 16% age 15.
Race/ Ethnicity	95% White, 1% African-American, 4% other (mostly Hispanic)

Program Components

☑ Adult Involvement
☐ Case Management
☐ Group Discussion
☐ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☐ Role Play
☐ Video
☑ Other Visual instructional aids (e.g., posters, pelvic model)

Program Length

A six-week period is required for the initial two-part visit and a follow-up appointment. Additional visits are scheduled as necessary.

Staffing Requirement/ Training

In addition to the regular clinic staff (e.g., gynecologist, nurse practitioner, receptionist), a counselor-educator is needed to review the Personal Information Form and lead the educational segment of each patient's first visit. All program staff should receive training in adolescent cognitive and sexual development.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

Adolescent family planning clinic patients are at high risk for noncompliance with contraceptive methods, discontinuation of clinic services and unintended pregnancy. According to previous research, the average teen waits nearly a year after becoming sexually active to make her first clinic visit; furthermore, one third of all teens make their first clinic visit for the purpose of obtaining pregnancy tests. Concerns that may lead teenagers to avoid family planning clinics include fear of parental disclosure, fear of the pelvic examination and fear of contraceptive methods. Family planning clinics do not typically address such concerns. In contrast, the *New Adolescent Approach Protocols Program* is based on the premise that family planning clinics can increase regular contraceptive use by offering teens information, social support and counseling, in addition to health and medical services.

A basic consideration guiding development of the program was teenagers' minimal medical needs in comparison to their need for information, social support and counseling. Among the special requirements considered during program development were the need for age-appropriate education, reassurance of confidentiality, information and reassurance about the pelvic examination, as well as counseling regarding such concerns as patients' apprehensions about contraception.

A field study of the program was conducted with 1,261 teens attending six family planning clinics in central Pennsylvania. Funding for the study was provided by the Ford Foundation.

Program Objectives

The program is designed to alter relevant features of family planning clinic service delivery to address young clients' fears and to increase their sense of comfort. Specifically, the *New Adolescent Approach Protocols Program* seeks to:

(1) increase the amount of contraceptive counseling and education provided to teen clients;

(2) identify client fears or concerns likely to interfere with effective contraception;

(3) provide teens with reassurance and social support;

(4) encourage the participation of teens' parents, friends and sexual partners, while respecting teens' right to confidential services;

(5) increase teens' comfort with the medical examination; and

(6) increase the opportunity for patient follow-up, allowing clinic staff to identify problems early on and provide additional counseling to high-risk teens.

Hypothesized Outcomes

By providing in-depth counseling and education, addressing young clients' fears and increasing their comfort with clinic procedures such as the pelvic examination, the program aims to increase effective contraception and decrease unintended pregnancy. Specifically, it is predicted that program participation will be associated with:

- increased comfort/satisfaction with the clinic;
- increased knowledge about effective contraceptive methods;
- increased confidence regarding contraception;
- more effective contraceptive use; and
- reduced pregnancy rates.

Educational Objectives

The intervention also includes the following educational objectives:

- to provide teens with basic information about anatomy, reproduction, contraception and sexually transmitted diseases;
- to address misconceptions and fears regarding clinic procedures and contraceptive methods;
- to provide descriptions of contraceptive alternatives, including abstinence;
- to explain what clients should expect from the medical and pelvic examinations; and
- to provide detailed instructions for the client's chosen method of contraception.

Program Content

The *New Adolescent Approach Protocols Program* encompasses a total family planning service delivery system for adolescents. Written protocols provide clinic staff with guidance on all aspects of agency activities, ranging from suggestions for making the environment "teen-friendly" to detailed guidelines for conducting the medical examination and patient follow-up. The major differences between the new protocols and traditional family planning services are: (1) in-depth, individualized counseling and education; (2) more frequent clinic visits; and (3) special staff training regarding adolescent sexual and cognitive development. Critical components of the intervention are highlighted below.

Agency Environment

The majority of agency environment guidelines are standard practice for all family planning agencies serving teens. The most significant change is the posting of additional instructional signs to help direct the teens at every step of their visit. For example, one program recommendation is to post a sign in the waiting room that reads, "Let the receptionist know you are here." Suggested posted instructions in the examination room tell patients, "How to prepare for your exam."

Staff Training

One of the cornerstones of the program is the fact that all clinic staff receive training in adolescent psychological and sexual development, as well as protocol administration.

First Contact with Patient

Very specific telephone protocols have been developed for the clinic receptionist. Additions to standard agency protocols include offering the teen directions to the agency, assuring confidentiality to every teen, providing specific information about what her visit will entail and asking if she needs a temporary birth control method for the interim period. Guidelines for dealing with clients who are only interested in pregnancy testing are also specified.

The program provides general guidelines for the receptionist's interaction with teens at their first clinic visit. Examples include personalizing the interaction by using the teen's first name, making sure to act in a sensitive manner, and providing the teen with condoms and foam as a temporary method of contraception.

Personal Information Form

A key component of the intervention is the *Personal Information Form*, a one-page questionnaire designed to help clinic staff understand teens' concerns, tailor the counseling and education session to their needs and developmental level, and identify patients at highest risk for unintended pregnancy. Teens who are very young, developmentally slow, lack future plans, lack parental support, think that pregnancy would be okay, have infrequent intercourse, have short term sexual relationships and/or have not initiated the family planning visit themselves are considered to be at especially high risk for unintended pregnancy.

The *Personal Information Form* also serves as a tool for counseling and educating teens in a family planning clinic. Questionnaire items prompt the teen to think about important issues, including plans for the future, misconceptions about birth control and the ways in which pregnancy may affect her life. After the teen completes the form, it is reviewed by the counselor/educator, who then discusses the responses with her. Specific protocol guidelines assist the counselor during this discussion.

Two-Part Initial Clinic Visit

The *New Adolescent Approach Protocols Program* splits the traditional "initial visit" into two parts for teen clients. The two appointments are generally scheduled no more than two weeks apart. At the first visit, the teen receives counseling/education regarding anatomy and physiology, sexuality, pregnancy, contraception, and sexually transmitted diseases. The counselor reviews the *Personal Information Form* with the teen, corrects any misperceptions, and provides general information regarding contraceptive alternatives, including abstinence. The purpose, procedures, and what to expect from the medical and pelvic examinations are also explained at this visit. Finally, the teen is given temporary birth control (condoms and foam) before she leaves.

At the second visit, teens undergo the medical and pelvic examinations, receive a prescription contraceptive and are provided with specific instructions regarding the contraceptive method they have chosen. A six-week follow-up appointment is also scheduled at this time.

The two-visit system accomplishes several objectives. First, it allows the teenager to absorb more information during the counseling and education session by reducing anxiety about the pending pelvic examination. Second, it allows the counselor to take more time with the client without disrupting clinic scheduling. Third, it puts the teenager in more frequent contact with the clinic.

Counseling and Education Sessions

Clinic staff are provided with a list of general points to address during the counseling and education sessions. Included are: specific guidelines for reviewing the *Personal Information Form* with patients; brief instructions for discussions about physiology and anatomy, contraceptive alternatives and sexually transmitted diseases; and detailed instructions to be provided once teens have chosen a contraceptive method. Counselors are reminded to individualize their sessions and to employ visual aids to make information more concrete.

Involvement of Others in the Family Planning Visit

The program strongly advocates that teens' parents, friends or sexual partners participate in family planning visits. Because the need for assurance of confidentiality is especially important to teens, a special sub-protocol has been designed to assist the counselor/educator in the event that a parent, boyfriend or friend accompanies the teen. In addition to providing reassurance about her right to confidential services, counselors are encouraged to spend time alone with the teen to determine what, if any, information she does not wish to disclose to the accompanying person(s).

Medical Examination

A summary of recommendations is provided for the medical examination, most of which are standard protocol for family planning clinics serving teens. Guidelines primarily focus on steps that staff may take to make the teenager feel as comfortable as possible during the examination.

Exit Counseling Session

The program also provides guidelines for counseling patients after they have received the medical examination, contraceptive prescription and specific instructions for the method they have selected. Although most of the guidelines are standard family planning clinic practice, the importance of providing teens with support and encouragement before they leave the clinic is underscored.

Patient Follow-Up

Teens are required to make a follow-up visit approximately six weeks after their initial visit. The purpose of this visit is to assess whether they are experiencing any problems with their contraceptive method and to provide additional counseling for high-risk teens. Additional visits are scheduled as needed, depending upon the contraceptive method chosen and the individual needs of the teen.

Program Schedule

A six-week period is required to implement the initial two-part clinic visit and the mandatory follow-up appointment. Additional visits are scheduled as needed, depending upon the teen's choice of contraceptive method and individual needs.

It is important to note that the *New Adolescent Approach Protocols* require about 45 additional minutes per client to administer, compared to the shorter, traditional family planning service protocols. The table below indicates the additional time required for each protocol, and the visit during which it is used.

Clinic Visit	*Protocol(s)*	*Additional Time*
General	**Agency Environment**	**N/A**
Visit 1: Part 1	First Contact	5 min.
	Counseling & Education[1]	15 min.
Visit 1: Part 2	Medical Exam	
	Counseling & Education[2] / Exit Counseling	10 min.
6-Week Follow-Up	Follow-Up	15 min.

[1] Includes following the sub-protocols: General Points, Personal Information Form, Other Person Involvement, and Brief Contraceptive Instructions.

[2] Includes following sub-protocol: Specific Method Instructions.

Program Materials: Replicating or Adopting *New Adolescent Approach Protocol*

The *New Adolescent Approach Protocol* Program Package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of this book. The package includes the following materials needed to implement this intervention in your family planning clinic. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Protocols Handbook

The *New Adolescent Approach Protocols Handbook* provides master copies of all program protocols. They guide clinic staff on all program activities, offering suggestions for making the agency environment more appealing to teenagers and detailed guidelines for medical examination and patient follow-up. Listed below is a brief outline of the protocols included in the handbook (sub-protocols are indicated by a bullet).

(1) Agency Environment

(2) First Contact

- Telephone Contact
- Teens' First Visit to the Agency

(3) Counseling and Education

- General Points
- Initial Visit Interview/Counseling Session
- The Personal Information Form
- Other Person Involvement
- Brief Instructions of Contraceptive Methods and STDs
- Specific Method Instructions

(4) Medical Exam

(5) Exit Counseling Session

(6) Follow-Up Contact

Personal Information Form

The *Personal Information Form* is a one-page, 16-item questionnaire that the patient completes in the reception area when she arrives for her first visit. Among the questions that are asked are: the reason for the patient's visit, how she feels about visiting the clinic, whether she is currently having sexual intercourse, whether she is using a contraceptive method (and if so, which one), whether her parents know about her visit, whether her partner knows about and approves of her visit, whether she has fears about or anticipates any problems with using a method of birth control, what her future plans are, and how she would feel about becoming pregnant. The form is primarily intended to be used as a counseling tool to identify potential problems and initiate discussion with the teenager. Once identified, specific fears about the effects of oral contraceptives or about the pelvic examination, for example, can be discussed at greater length. Guidelines on how to administer the *Personal Information Form* are provided in the *Protocols Handbook*.

Teen Educational Pamphlets

In the field study of the program, the following educational pamphlets were available for teens in the clinic waiting room.

- *Birth Control: Talking with Your Parents*
- *Condoms: Talking with Your Partner*
- *STD Facts*
- *Sex & HIV*
- *Your Contraceptive Choices*
- *Your First (Or Twenty-Third) Pelvic Exam*

Twenty-five copies of each pamphlet are included in the PASHA program package as a starting point for implementing this program. Feel free to add other materials that would also be appropriate.

Additional Materials

The PASHA program package provides everything needed to implement the *New Adolescent Approach Protocols Program*, except for the following materials: teen-appropriate reading material and decorative posters, which should be available in your community, and visual instructional aids (such as posters of the reproductive system, pelvic model, etc.), which should be available in your clinic. In addition, clinic staff can easily create the patient instructions which should be posted in reception and examination areas (i.e., "Let the receptionist know you are here," "How to prepare for your exam").

How to Implement the Program

Training

One of the key aspects of this program is the fact that all project staff receive training in: (1) protocol administration and (2) teen sexual and cognitive development. In the original field study of the program, clinic staff attended a special two-day training session prior to administering any of the protocols. Day 1 was devoted to lectures on adolescent psychosocial and cognitive development and adolescent sexuality. Day 2 was devoted to instruction on implementing the protocols and the various evaluation measures. You may want to organize a similar session for your staff.

Staffing

During the original field study, a project coordinator was designated at each participating clinic site; this individual was responsible for supervising program implementation and collection of the evaluation data. Additionally, the project coordinator was responsible for: (1) training staff hired after the initial training session; (2) supervising staff who were involved in implementing the protocols; and (3) examining all forms to ensure correct completion.

Protocol Problems

Overall, in the field study of the program, staff reported few problems in using the new protocols. However, clinic schedules needed to be altered significantly to allow for the additional time required to follow the protocols. Additional staff time was also required to train personnel who had been hired after the study began.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the *New Adolescent Approach Protocols Program* was investigated in a field study involving 1,261 teenage girls attending six non-metropolitan family planning clinics. Three sites agreed to use the new family planning protocols, and three others continued with their usual service delivery practices. The study compared contraceptive use and pregnancy outcomes between teens receiving the two types of services.

To examine the effect of the program over time, measures were taken at three points:

- Time 1: The patient's first clinic visit during the field study period (Index Visit);
- Time 2: Six months following the first visit (Six-Month Follow-Up); and
- Time 3: One year following the initial visit (12-Month Follow-Up).

In addition, a group of 251 teens completed two surveys during a preliminary phase of the study.

Evaluation Questions

The field study addressed the following questions.

(1) Do the *New Adolescent Approach Protocols* increase teens' sense of comfort with the clinic?

(2) Do the *New Adolescent Approach Protocols* help young clients use contraception more effectively?

(3) Do the *New Adolescent Approach Protocols* help young clients avoid pregnancy?

(4) Does the increased frequency of clinic visits required by the *New Adolescent Approach Protocols Program* lead to greater attrition among teenage patients?

Site Selection

Six family planning sites were contracted to participate in the project. Of this group, three clinics agreed to use the *New Adolescent Approach Protocols Program* (Lock Haven Family Planning, Adams County Family Planning and Health Center, and Mifflin/Juniata/Huntingdon Women's Health Services), and the remaining three, serving as comparison sites, continued with their regular program of service delivery (Family Health Services of South Central Pennsylvania, Altoona Hospital Family Planning, and Family Health Services, Inc.).

The evaluators' choice of clinics was guided by several criteria. First, all sites participating in the study showed comparable demographic characteristics, including racial and age distribution, per capita income of municipalities and percentages of families below poverty. Second, the clinics employed the same staffing pattern—a modified form of primary nursing in which the client interacts with a receptionist and only one or two other staff members during her visit. And, importantly, patient continuation rates during the year prior to the study were higher in the comparison sites than in those using the *New Adolescent Approach Protocols Program*. This was a safeguard to ensure that program clinics showed no advantage in patient retention prior to the study.

Random assignment of clinics to treatment condition was not possible, because some of the clinic directors were unwilling to make the changes in patient scheduling that would be required to implement the new program.

Staff Training

Two special training sessions were held for agency project coordinators—one for sites implementing the *New Adolescent Approach Protocols Program* and one for the comparison sites. Topics covered included project coordinator responsibilities, evaluation tools, timelines and scheduling considerations.

Data Collection Procedures

During the two-month preliminary phase of the study, measures of patient knowledge and satisfaction were collected from 251 teenagers who made initial or annual visits to the six participating clinics. Because random assignment of patients to condition was not possible, it was especially important that study sites be equivalent prior to the intervention. Comparisons of these preliminary data revealed that although there were no differences in knowledge scores between the participants at the program and comparison group sites (indicating that the sites were similar in terms of the information they were providing to clients), satisfaction scores were higher in the program sites ($p < .05$). One possible explanation for this difference is that program staff planning to use the new protocols might have shown increased enthusiasm in their work (a phenomenon also referred to as the "Hawthorne Effect"). It is also important to note that some staff members at program sites had participated in the development of the intervention and may have begun implementing parts of the program before the study officially started.

Data Collection Schedule

The data collection schedule for the study is shown below.

	Preliminary Measures	*Index Visit*	*6-Mo. Follow-Up*	*12-Mo Follow-Up*
Knowledge Quiz	X	X	X	X
Satisfaction Survey	X	X		
No Show / Continuation Report		X	X	X
Method Use Questionnaire		X	X	X

Research Sample

A total of 1,261 patients took part in the study. The majority of this group (62%) were making initial clinic visits; 39% were making annual/return visits. Although participants ranged between 11 and 18 years of age, nearly three-fourths of the teens were either 16 or 17. The few participating 18 year-olds—all considered to be at high risk for early pregnancy—were enrolled at the discretion of clinic staff.

The sample was almost exclusively White (nearly 98%), with a few African-American and Hispanic participants. The single largest religious group in the sample was Roman Catholic (22%), followed by Methodist (18%) and Lutheran (10%).

Preliminary knowledge and satisfaction data were collected from 251 patients. During the six-month treatment phase of the study, data were collected on an additional 1,010 patients (425 at program sites, 585 at comparison sites).

Evaluation Results

Evaluation measures assessed: (1) the knowledge patients acquired during the course of the program; (2) patient satisfaction with clinic services; and (3) contraceptive-related behaviors and outcomes, including pregnancy. The effect of the *New Adolescent Approach Protocols Program* on each of these outcomes is discussed separately below.

Patient Knowledge

In general, clients at all sites scored quite high on the Knowledge Quiz. In fact, all but five of the eleven items were answered correctly by at least 95% of the clients. Nevertheless, in both administrations of the quiz, clients at program clinics scored significantly higher than their comparison group peers ($p < .0001$ for both). Since the sites did not differ on this measure during the preliminary phase of the study, differences in the teens' scores can only be attributed to the intervention.

Client Satisfaction

Program evaluators found no evidence that the program sites produced significantly greater patient satisfaction than the comparison sites. In general, patients in both sites reported very high levels of satisfaction with clinic services, with mean scores for most clients falling between 9 and 10 (10 representing the highest possible score).

Continuation Rates

Continuation rates during the year following patients' index visits were equivalent for the two groups of teens, with 39% of program participants and 38% of their comparison group peers returning for their twelve-month visits. In addition, the division of the first appointment into two visits did not seem to be a problem for program participants, as nearly all attended their second visit. In sum, teens who took part in the *New Adolescent Approach Protocols Program* did not drop out at a higher rate than those who received standard services.

Contraceptive Method Use

The Method Use Questionnaire, which was completed by a clinic staff member at the Six- and Twelve-Month Follow-Up assessments, measured clients' contraceptive experiences, including method problems, side effects, and whether the client had continued using the same method or had changed to a different method (and if so, which method). The questionnaire also assessed whether a pregnancy had occurred since the Time 1 assessment.

- **Use of Original Contraceptive Method**: In general, the large majority of clients in both groups of clinics who returned for follow-up visits continued to use the method they were initially prescribed. However, significantly more program clients than comparison group clients stayed with their original method at both the Six-Month (92% and 85%, respectively, $p < .001$) and Twelve-Month assessments (90% and 81% respectively, $p < .05$).
- **Use of Any Contraceptive Method**: The percentage of program participants who continued to use any method (their original method or any other, including condoms) consistently exceeded that of their comparison group peers. However, the difference was statistically significant only at the Six-Month Follow-Up assessment. ($p < .001$).
- **Difficulty Dealing with Method Problems:** Clients were asked to rate their experience coping with method problems. At six months, program participants reported significantly greater ease in coping ($p < .01$) than did their comparison group peers. At twelve months, this pattern held only for those teens whose index visit was their initial clinic visit, and the difference in coping was only marginally significant ($p < .10$).
- **Continued Use of Method Despite Problems**: Investigators explored whether teens continued to use their contraceptive method after experiencing a problem (either a side effect or other problem, such as cost or partner objections). At the Six-

Month Follow-Up, 79% of program participants, but only 56% of comparison group members, continued to use their method despite experiencing one or more problems ($p < .001$). This difference was even larger at the Twelve-Month Follow-Up ($p < .001$), with over 70% of program participants (vs. 40% of comparison group members) continuing to use their method despite problems.

- **Pregnancy Rates**: There were a total of 45 known pregnancies during the year following the preliminary assessment—13 in program sites and 32 in comparison sites. This difference was marginally significant ($p = .06$).

Summary

Compared to their peers receiving standard family planning services, teenage clients participating in the *New Adolescent Approach Protocols Program*: (1) learned more during the educational session; (2) were more likely to be using their original contraceptive method (or any method); (3) experienced less difficulty in dealing with method problems; and (4) were more likely to continue using their prescribed method, despite problems, at the Six-Month Follow-Up assessment. Furthermore, teenage patients who attended program clinics were somewhat less likely to become pregnant over the following year than those who received standard family planning services.

The evaluators also found that the new protocols were not associated with a greater drop-out rate by family planning patients. Yet, contrary to expectations, patients who received the new protocols did not report significantly greater satisfaction with clinic services. Program participants and their comparison group peers reported equivalent, high levels of satisfaction with the family planning services they received.

Overall, the findings lend support to the idea that teenage family planning patients benefit from specialized services. The tailored protocols helped teen patients use their methods successfully, continue to use them despite problems, deal with problems more easily and use another method after switching from their original method. Moreover, the protocols seemed to have helped patients avoid pregnancy.

The cost of the intervention was primarily due to the extra personnel time needed to counsel and instruct patients. Still, the researchers concluded that the time and effort required to meet teens' special needs were justified by the youths' improved knowledge, increased contraceptive use and lower pregnancy rates.

Future Evaluations of this Program

The researchers felt that their evaluation was hampered by the inability to determine what happened to clients who dropped out of the study. They also had to exclude follow-up data for many clients who returned late for their annual visit. A proportion of "drop outs" may have simply been tardy in scheduling their twelve-month visit and would have provided data had the follow-up period been longer.

Furthermore, the researchers expressed some concerns regarding the evaluation measures, particularly the Knowledge Quiz. While the quiz did yield interpretable data, the overall scores were very high and the reliability low. It is recommended that future studies use a longer and more difficult quiz. In addition, the evaluators found an overwhelmingly positive bias in Client Satisfaction Survey ratings. Finally, clinic staff had difficulty maintaining the No Show/ Continuation Reports that recorded clients' compliance with appointments. As a result, program evaluators used the number of clients who completed the Method Use Questionnaire at the Six- and Twelve-Month Follow-Ups to calculate patient continuation rates.

The evaluators recommended that future studies employ a more vigorous follow-up system, fewer measures (a more challenging quiz, administered once and the Method Use questionnaire), and a longer treatment phase and follow-up period to track patients and obtain outcome data. This design should be easier for clinics to implement, require less data management, and yield a larger sample size with greater information on drop-outs.

Evaluation Materials for *New Adolescent Approach Protocol*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments*, the *Prevention Minimum Evaluation Data Set (PMEDS)* and the *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Instruments

The field study of the *New Adolescent Approach Protocols* was designed to assess three broad components of clients' experiences: knowledge acquired, feelings about the clinic, and behavior—specifically, contraceptive use, clinic attendance and pregnancy status. The tools developed for the evaluation are discussed below.

Knowledge Quiz ("What Do You Know?"). This quiz consists of 11 true-false questions designed to assess clients' understanding of basic reproduction, contraception and sexually transmitted diseases. After completing the quiz, clients are provided with the correct answers so that misunderstandings can be corrected.

Client Satisfaction Survey. This 9-item questionnaire assesses the client's family planning clinic experience. The survey includes demographic measures and questions probing the client's feelings about specific aspects of her clinic visit (such as staff responsiveness, waiting time and comfort level).

No Show/Continuation Report. This report gathers information about clients' attendance at scheduled appointments. Measures include: the date the client called for an appointment, the date her first visit was scheduled, whether the client kept the appointment (or, if not, called to reschedule and then kept the new appointment), the dates of subsequent appointments and whether those appointments were kept or rescheduled. During the original field study, the form was completed by the agency receptionist.

Method Use Questionnaire. This form assesses clients' success in using their prescribed contraceptive methods. The form is completed by a clinic staff member at the patient interview held during each follow-up visit. The Method Use Questionnaire gathers information about the client's contraceptive experience, including method problems, side effects, and whether the client continued using the same method or changed to a different method (and if so, which method). The questionnaire also assesses whether a pregnancy occurred since the first visit.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *New Adolescent Approach Protocol*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

8

Teen Talk
An Adolescent Pregnancy Prevention Program

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Program Abstract

Title **Teen Talk**

Summary

This is a collaborative school- and community health centers-based sex and contraception education intervention intended to reduce adolescent pregnancy. The 12- to 15-hour program begins with two large-group, lecture format presentations covering reproductive physiology, contraception methods, and contraceptive effectiveness. During the remaining four sessions, students participate in small group discussions that are designed to: (1) help teens understand and personalize the risks and consequences of teenage pregnancy; and (2) develop and practice the skills that will make abstinence or obtaining contraception easier decisions to implement. The sessions include games, role plays, and trigger films that encourage group discussion. A field study of the intervention was conducted in both rural and urban communities in Texas and California. Teens of diverse ethnicities recruited from different agencies and schools participated. Participation in the program was especially beneficial to males, leading to a delay in the onset of sexual activity among male virgins, and to the use of more effective contraception among male non-virgins.

Focus

- ☑ Primary pregnancy prevention
- ☐ Secondary pregnancy prevention
- ☐ STD/HIV/AIDS prevention

Original Site

- ☑ School-based
- ☑ Community-based
- ☐ Clinic-based

Suitable for Use In

Teen Talk can be implemented in community-based organizations, schools and school districts, or as a collaboration between community organizations and schools.

Approach

- ☐ Abstinence
- ☑ Behavioral Skills Development
- ☐ Community Outreach
- ☐ Contraceptive Access
- ☑ Contraceptive Education

☐ Life Option Enhancement
☐ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/AIDS/STD Education

Original Intervention Sample

Age, Gender	The original sample included male and female students between the ages of 13 and 19: 29% were ages 13-14; 67% were ages 15-17; 4% were ages 18-19.
Race/ Ethnicity	The original sample population was composed of the following: 15% White; 24% African-American, 53% Hispanic, 8% Other.

Program Components

☐ Adult Involvement
☐ Case Management
☑ Group Discussion
☑ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☑ Role Play
☑ Video
☑ Other Games, audiotape

Program Length

This program is designed to last a total of 12-15 hours. The program schedule is relatively flexible and can be adjusted to suit the particular site. However, it is recommended that the program be given over a span of two to three weeks: the initial lectures in two 2-hour sessions; and the subsequent group discussions in four 2- to 2 1/2-hour sessions.

Staffing Requirements/ Training

The program requires one lecturer per classroom and one group discussion leader to work with eight students. A two-day intensive training workshop is recommended to train all group leaders on how to conduct effective group discussion sessions and to familiarize them with the program format and content. The PASHA program package includes comprehensive staff training materials.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

Teen Talk is a theory-based adolescent pregnancy prevention program. This program was developed as a public health approach to sexuality and contraception education and incorporates lectures with group discussions. It was originally field tested in several community-based health centers and schools over a four-year period (1984-1988).

Teen Talk was implemented in youth groups, health classes and other community education programs as an alternative to their "usual care" sex and contraception educational outreach curriculum.

This program was supported with funding from the National Institute of Child Health & Human Development, state and private foundation sources.

Theoretical Framework

The development of *Teen Talk* was guided by two theoretical perspectives, the Health Belief Model (HBM) and Social Learning Theory (SLT). They can be viewed as complementary ways of understanding individual behavior change and are often applied to issues of health behavior modification and primary prevention.

Principles of the Health Belief Model suggest that individuals will be likely to engage in health-related behaviors when the following conditions are met.

(1) One perceives that the problem (e.g., teen pregnancy) poses a threat to one's well-being.

(2) One understands the benefits of and barriers to taking preventive action.

(3) One feels a sense of efficacy in carrying out the recommended actions.

Bandura's Social Learning Theory (SLT) elaborates the processes through which intentions can be translated into behavioral change among teens. Bandura asserts that learning occurs through practice and observation of social models; it is mediated by internal beliefs about one's ability to succeed, as well as by others' evaluation of the individual's performance.

Program Objectives

The goal of the program was to research the effectiveness of the theoretical model in affecting health knowledge, attitude, and behavior change. Two behavioral objectives are specified:

- to increase unmarried adolescents' knowledge of and motivation for fertility control, i.e., abstinence or consistent use of effective contraception; and
- to determine the impact of *Teen Talk* with respect to participants' subsequent sexual behavior, contraceptive use and pregnancy status.

Hypothesized Outcomes

It is hypothesized that a program such as *Teen Talk* that applies the principles of the HBM-SLT model by incorporating both didactic and active learning will be associated with:

- lower incidence of transition to sexual activity status during the one-year follow-up period;
- higher incidence of effective contraceptive use at first and most recent intercourse among those who become sexually active;
- higher incidence of effective contraceptive use at most recent intercourse among teenagers who are sexually active prior to the intervention.
- more consistent use of effective contraception among those who are sexually active over the one-year follow-up period; and
- older average age at first intercourse for teenagers who become sexually active during the follow-up period.

The researchers assumed that the *Teen Talk* program model would not be equally effective with all age, gender, racial/ethnic and sexual status groups or in all study sites. Little empirical basis exists, however, for predicting the direction or the magnitude of potential differences.

Educational Objectives

The 12- to 15-hour program is intended to increase teenagers' knowledge and awareness of the following:

- the probability of personally becoming pregnant or causing a partner to become pregnant;
- the serious negative personal consequences of teenage maternity and paternity; and

- the personal and interpersonal benefits of delayed sexual activity and consistent, effective contraceptive use.

In addition, the program aims to decrease:

- the psychological, interpersonal, and logistical barriers to abstinence and consistent contraceptive usage.

Program Content

Teen Talk is based on four basic components. These components form the content of the two lecture sessions and the four discussion sessions.

(1) **Presentation of Factual Information**. This information is presented to the teens in the initial two large-group lectures. The lectures cover topics such as reproductive biology, venereal disease and contraception and are intended to provide the teens with factual knowledge about sexuality and contraception.

(2) **Group Discussion of Factual Information**. Issues that draw upon the lecture material are discussed in small groups. Discussion emphasizes basic concepts of probability and pregnancy risks; social, educational and economic consequences of premarital pregnancy and parenthood; and pregnancy resolution options, including adoption and abortion.

(3) **Group Discussion of Values, Feelings, and Emotions**. Further personalization of sexuality issues continues in discussions which emphasize communication in relationships with same-sex peers and opposite-sex boyfriends or girlfriends, as well as for one's own feelings about sexuality.

(4) **Making Decisions and Taking Personal Responsibility**. In order to solidify these issues in concrete action, this component emphasizes actual decision-making; making personally and sexually responsible decisions and learning new skills to implement those decisions.

Program Schedule

Teen Talk is designed to last a total of 12-15 hours. The program schedule is relatively flexible and can be adjusted to suit the particular needs and constraints of the site. However, it is recommended that the program be given over a span of two to three weeks: the initial lectures in two 2-hour sessions; and the subsequent group discussions in four 2- to 2 1/2-hour sessions. The lecture curriculum material as well as the group discussion material (see Program Materials, below) is described according to recommended duration.

Lecture Sessions

The curriculum materials for the two lectures are contained in the *Reproduction and Contraception Curriculum* booklet. This booklet contains comprehensive lessons including overheads.

Lecture session 1 should present the material in Part 1 (Anatomy and Physiology) and Part 2 (Sexually Transmitted Diseases) of the curriculum.

Lecture session 2 should present the material in Part 3 (Contraception) and Part 4 (Prenatal Development and Care).

This curriculum is a relatively standard sexuality education curriculum. You may want to adapt and/or augment the material or substitute your own curriculum, provided that the participants learn the same information. This lecture material is important preparation for the four small group discussion sessions—the heart of the *Teen Talk* program.

Group Discussion Sessions

The small group discussions (2 to 2 1/2 hours each) are designed to help group members understand and personalize the risks and consequences of teenage pregnancy and to develop and practice the skills that will make abstinence or obtaining contraception easier decisions to implement. Detailed guidelines for each of the four discussion sessions are contained in the *Group Discussion Curriculum Guide* in the PASHA Program Package.

The four small group discussions are described below.

Group Discussion Session 1: Risks and consequences

(1) Session 1 begins with introductions.

(2) Group rules are discussed.

(3) The first formal exercise (Communicating in Pairs) is designed to show that without good skills, communication can be very difficult and frustrating. (40 minutes)

(4) The *Spinner Game* is designed to help young people really understand what the risks of unprotected intercourse are. (20 minutes)

(5) The film "Wayne's Decision" is shown in order to help group members understand what the consequences of an unwanted pregnancy can be. (15 minutes)

(6) The session should be brought to a close by asking the group, "How many of you want to be sure that what happened to Wayne and Donna never happens to you?" (10 minutes)

Group Discussion Session 2: How to avoid those risks and consequences

(1) This session begins with a warm-up and review of the previous session. This review will include a discussion of the consequences of an unwanted pregnancy.

(2) Once the consequences are reviewed, a discussion of all the ways to prevent such an unwanted pregnancy begins. (15 minutes)

(3) This session now focuses on communication skills. *Teen Talk* presents the skills in order of difficulty, so that group members can first practice and receive reinforcement on easier tasks. (20 minutes)

(4) Role play provides group members an opportunity to practice these skills.

(5) The final exercise shows students how to say "no." This concept is introduced by the film "Mark and Susan," which portrays a boy pushing a girl to have sex when she really does not want to.

(6) The session ends with a short review and a preview of the next session, addressing communication skills in greater detail.

Group Discussion Session 3: Communication

Focusing on communication skills, this session emphasizes the ability to say "no" to intercourse. For those who may decide to say "yes," the session teaches group members how to acquire contraceptive devices.

(1) This session begins with each member sharing what he or she has learned from *Teen Talk* so far. (20 minutes)

(2) The film "Mark and Susan," shown in Session #2, is reviewed. The purpose of this review is to emphasize that Mark and Susan can make just two responsible decisions: they can decide to abstain from sex or they can mutually decide to have sex.

(3) Two sets of role plays follow from the two alternatives discussed above.

(4) At the end of the session, each group member is asked to commit to returning for the final *Teen Talk* session. (10 minutes)

Group Discussion Session 4: Boy-girl communication and review

(1) After a brief warm-up, the session begins with a film called "What's to Understand?" This film portrays how difficult it is to communicate in sexual situations.

(2) The film sets up two final role plays.

(3) The game "Family Feud" is introduced to help group members review what they have learned. It is played in much the same manner as on television.

(4) It is recommended that the group end with an informal party—a chance to socialize and enjoy refreshments together.

Prior to the first session, immediately after the last session and twelve months after the last session, you may want to interview your teen participants to ascertain the program's impact on their knowledge, attitudes and behavior. A set of Interview Training Materials and Instruments is provided in the PASHA program package and discussed in the Evaluation below.

Program Materials: Replicating or Adopting *Teen Talk*

The *Teen Talk* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of this book. Two sets of materials and curricula are used for implementing the *Teen Talk* program and are included in the PASHA program package. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package

Education Curriculum

The first set is used for the sexuality education lecture sessions.

Reproduction and Contraception Curriculum. The reproductive biology curriculum guide consists of approximately four hours of lecture material (two 2-hour sessions) covering major aspects of reproductive biology, venereal disease and contraception, directed specifically to adolescents.

Master copies for the handouts and/or overheads are included in the packet entitled *Handout/Overhead Masters*.

Group Discussion Materials

The second set of materials is used by program leaders for the four group discussion sessions. The following components are included:

Training Manual for Group Discussion Leaders. This manual presents an overview of the Health Belief Model theory, a rationale for extending it to teen pregnancy and STD prevention, tips on running small groups and commentaries on each of the four (1/2 hour) training tapes.

Training Videotapes for Group Discussion Leaders. The set of instructional videos consists of four (1/2 hour) programs (condensed onto two videotapes) designed to familiarize prospective leaders with broad program components and specific activities. The tapes use simulations and re-creations of actual program content. Adolescents who have "graduated" from the pilot study program portray new participants, and former discussion leaders act as trainers.

Please note that these videotapes will seem outdated and of poor quality by today's standards. Although these were developed to show to program staff during training, you may wish to simply use them as a model upon which to base your own staff training sessions.

Group Discussion Curriculum Guide. The small group discussions operationalize the HBM concepts by emphasizing social learning theory principles such as modeling, guided practice and social and self-reinforcement for appropriate actions. This manual provides step-by-step instructions on how to conduct each small group discussion session.

Trigger Films

Trigger Films for use in small group discussion are also included in the PASHA program package. These films were produced by Planned Parenthood affiliates. "Wayne's Decision," "Mark and Susan," and "What's to Understand?" use teenage actors to make as real as possible teens' susceptibility to pregnancy and the serious consequences that result. After viewing the films, participants may generate their own scripts to role-play key sex- and contraception-related situations (e.g., learning to say "no" to sexual intercourse or unprotected sexual intercourse; learning to buy over-the-counter birth control materials in a drug store).

It should be noted that the three *Trigger Films* may be perceived as of poor quality and out-of-date—they were developed in the early 1980s. Teens may not respond favorably to out-of-style clothes, music, colloquialisms, slang, etc. Although these films do not contain sexually explicit scenes, one of them, "Mark and Susan," depicts a parked car (you do not see the teens in the back seat) but you hear Mark pressuring Susan to have sex without using a condom. If you feel the *Trigger Films* are unsuitable for your teens, the following videos are recommended as possible substitutes:

Saying No...A Few Words to Young Adults About Sex. This 18-minute video emphasizes the self respect teens gain as a result of responsible decision-making. It may be obtained from:

Perennial Education
930 Pitner Avenue
Evanston, IL 60202
800-323-9084

Clear Vision: How Adolescent Males View Teenage Pregnancy. This 26-minute video uses humor to look at sexual responsibility and teen parenthood. The video includes a Discussion Guide and a Classroom Poster, and can be obtained from:

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061-1830
800-321-4407

Rockabye: Understanding the Implications of Teenage Pregnancy. This 17-minute video offers triggers for class discussion about teen sexuality, pregnancy, and parenthood. The video includes a Program Guide with suggestions for follow-up activities, and can also be obtained from:

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061-1830
800-321-4407

Additional Materials

The PASHA program package provides all of the primary curriculum materials (mentioned above) needed to implement *Teen Talk*. However, additional equipment which should be readily available in your community or school is required for some of the sessions, including a TV and VCR, photocopier, a chalkboard or flip chart and markers for group discussions. You will also need examples of contraceptive products—such as condoms, lubricant, diaphragms, birth control pills, sponge, etc.—which can be obtained at a local pharmacy or drug store.

In the field test, a graduation ceremony was held and each participant received a certificate and a T-shirt with the program logo. Although these awards are optional, the program developers found that the participants were genuinely proud of their certificates. The T-shirts also became recruiting and public relations tools that brought positive attention to the program.

How to Implement the Program

Training Workshop

In the original field study, a two-day workshop was held to prepare leaders to implement the program with teens. You may want to organize a similar training session for your own staff.

During the workshop, all of the program materials (the *User's Guide, Training Manual* and *Training Videotapes*, a *Group Discussion Curriculum Guide*, as well as the *Reproduction and Contraception Curriculum* manual and *Trigger Films*) should be reviewed.

On the first day of training, *Teen Talk* group leaders discuss:

- their role as group leader;
- how to present *Teen Talk* activities;
- how to run a productive group; and
- group development and maintenance.

Make sure to provide opportunities for staff to practice facilitating group discussions; you might also include role-play exercises. Encourage participants to ask any questions they may have about the curriculum.

During the second day of the workshop, participants view the following four training video segments (included in the PASHA program package).

- *Training Tape 1* introduces *Teen Talk* and the trigger films, guided discussions, role playing and games that are used to achieve the program's objectives.
- *Training Tape 2* discusses the sequencing of *Teen Talk*. Rules and guidelines are suggested for group leaders, and Group Session #1 is introduced.
- *Training Tape 3* introduces the curriculum used during Group Session #2.
- *Training Tape 4* presents information on Group Sessions #3 and #4.

At the end of this two-day training your program staff will be ready to implement *Teen Talk* with your teenagers.

Evaluating the Program

The Original Evaluation

Design

The original evaluation of *Teen Talk* approximated a randomized field trial. Six family planning service agencies and two grades of one independent school district (representing a total of eight sex and contraceptive education programs) compared their own "usual care" outreach or regular classroom curriculum with the *Teen Talk* program. Each agency recruited its study sample by its usual methods; the school district used its eighth- and ninth-grade population. Across sites, participation was open to all youth between the ages of 13 and 21; no attempt was made to balance the sample by gender, race/ethnicity or pre-intervention sexual activity status. At each site, participants were assigned by classroom unit or individually (at some agencies) to the agency's usual program (comparison group) or the *Teen Talk* program (experimental group). Data were collected from individual participants at three points during the study period:

- Time 1: before exposure to the intervention;
- Time 2: immediately following the intervention; and
- Time 3: 12 months after the scheduled program completion date.

Evaluation Questions

To assess the outcomes of the field experiment, the program evaluators attempted to answer the following questions.

(1) Were teens who were not yet sexually active more likely to remain virgins if they had received the *Teen Talk* intervention? Did significant sex or race/ethnicity differences exist in treatment effects between the *Teen Talk* and comparison programs?

(2) Were experimental program teens who became sexually active following the intervention more likely to report initial and consistent contraceptive use than youth in the comparison program? Were there sex or racial/ethnic differences in program effectiveness?

(3) Did significant increases occur in contraceptive efficiency from Time 1 to Time 3 among sexually active teenagers? If so, was the *Teen Talk* program more effective than the comparison programs in producing these improvements? Were there sex or race/ethnicity differences in program effectiveness?

(4) Were Time 2 health beliefs and sexual knowledge significant predictors of adolescents' fertility control behaviors, i.e., continued abstinence or contraceptive usage at Time 3? Did the perceptual and knowledge changes (if any) mediate or augment relationships between treatment conditions and fertility control behaviors?

The overall analysis plan involved a four-group approach: (a) Time 1 virgins' abstinence; (b) transition to sexual activity; (c) initiation of contraceptive use; and (d) Time 1 nonvirgins' contraceptive behavior were all examined separately for each sex. Researchers measured abstinence continuation; transition from virginity to sexual activity; and use and changes in use of effective birth control methods at first and most recent post-intervention intercourse. Effective contraceptive methods included pill, condom, diaphragm, foam/jelly and sponge; ineffective methods were withdrawal, rhythm and douche.

Data Collection Procedures

Community-based agencies were recruited from two pools: (1) organizations that conducted sexuality education outreach programming with state reimbursement agreements in Texas; and (2) educational groups that received "innovative" information and education (I & E) grants in California. The Texas Department of Human Services Director of Family Planning helped recruit eligible agencies in Texas. In California, the Chief, Office of Family Planning, and the Executive Director of the California Family Planning Council referred the program evaluators to potential sites in their state. A small independent school district in California's San Francisco Bay area also volunteered to participate in the project as a means of evaluating their curricula for family life and drug/problem behavior education.

The community-based agencies and the school district recruited all participants for the study, organized and coordinated the data collection and delivered the actual intervention. The agencies were paid up to $5,000 (the exact amount was based upon the number of teenagers recruited and retained in the sample) over the study period. The agency sample represented a relatively broad mix of service provider organizations, ranging from an urban Planned Parenthood affiliate to a rural community action program health clinic. The agencies were not representative of all agencies conducting educational outreach nationally, but they did appear typical of agencies and community-based outreach programs operating around the country.

Between June 1986 and August 1987, 1,444 adolescents (ages 13 to 19) completed the baseline (Time 1) interview, and 1,328 (92%) received all or part of the *Teen Talk* or comparison intervention and completed the immediate post-test (Time 2) interview. Agencies attempted to re-interview all adolescents who were exposed to any phase of the project 12 months after the scheduled completion date of their particular intervention program, even if the youth did not actually complete it. Between July 1987 and September 1988, 888 participants (62% of the Time 1 sample and 67% of the Time 2 sample) received the one-year follow-up (Time 3) interview to assess program impact. Included were 839 participants (58% of the Time 1 sample, and 63% of the Time 2 sample) from the seven sites who completed all three data collection cycles, i.e., baseline, immediate post-test and one-year follow-up.

Evaluation Results

The intervention results were encouraging, but mixed. Sexual experience (Time 1 virginity/non-virginity) and gender were important mediators of the effects of the *Teen Talk* and comparison programs on key pregnancy avoidance measures.

Time 1 Virgins' Abstinence

For those who had not had intercourse prior to the intervention, more males in the *Teen Talk* program maintained their abstinence over the follow-up year ($p<.05$). For females, no difference was found between the *Teen Talk* and comparison programs.

Transition to Sexual Activity & Initiation of Contraceptive Use

Female Time 1 virgins who attended the comparison programs were more likely to use an effective contraceptive method at their most recent intercourse and more likely to use contraception than those who attended the *Teen Talk* program ($p<.01$). The *Teen Talk* program and comparison programs were equally effective for sexually inexperienced males. Both programs significantly increased contraceptive use.

Time 1 Non-Virgin Contraceptive Behavior

Sexually active teens in both programs increased their contraceptive use. For males, *Teen Talk* led to significantly greater follow-up contraceptive use than did the comparison programs ($p<.05$); for females, the interventions produced equivalent improvement.

Positive Time 2 perceptions of the Benefits of Effective Birth Control Use predicted contraceptive efficiency for two of the four analytic groupings, and predicted transitions to sexual activity in the follow-up year for males. Finally, exposure to sexuality education prior to the study was associated with greater Time 3 contraceptive use, regardless of the program attended, for two of the four groups.

Summary

In summary, the *Teen Talk* intervention, with its emphasis on refusal skills, role playing and guided practice, was more effective for high risk males in the sample experimental group than in the comparison groups, but it appeared to have less salience for females in general, and for females who were just making the transition to sexual intercourse in particular. Even so, this field experiment is the first published, prospectively designed outcome evaluation to demonstrate a significant increase in sexually experienced teenagers' use of effective contraceptive methods over at least a one-year follow-up period. It is also the first published evaluation featuring random assignment of participants to intervention programs to show significant impact in delaying first intercourse over at least a 12-month period for either males or females.

Evaluation Materials for *Teen Talk*

In addition to the program materials described in an earlier section, the PASHA program package contains three resources for evaluation: instruments used in the original evaluation, the *Prevention Minimum Evaluation Data Set (PMEDS)* and the *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

The original evaluation materials included in the PASHA package include:

Training Manual for Interviewing Teens. The manual familiarizes program leaders with the *Teen Talk* program and its interview component. An important part of the program is the teen interview administered before and after participation in the educational sessions. The interview is the teen's first contact with the program, and it provides information for research purposes.

Student Questionnaires. These include one for pretest (to be administered before the first program lecture session), one for immediate post-test (to be administered after the program's last group discussion session), and one for the 12-month follow-up assessment.

The *Training Manual* and the *Training Tape for Interviewing Teens* provide tips on how to administer the student questionnaires; these should be reviewed first.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Teen Talk*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

9

A Health Care Program for First-Time Adolescent Mothers and their Infants

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Bibliography	O'Sullivan, A. & Jacobsen, B. (1992). A randomized trial of a health care program for first-time adolescent mothers and their infants. *Nursing Research*, 41, 210-215.

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Program Abstract

Title

A Health Care Program for First-Time Adolescent Mothers and their Infants

Summary

Originally designed for low-income, unwed teens, this program combines secondary and tertiary prevention goals. It aims to help first-time mothers prevent repeat pregnancies, return to school, improve immunization rates for their infants and reduce their use of hospital emergency room services for routine infant care. A variety of services are offered in the context of a teen baby clinic, including: (1) well-baby care at 2 weeks, and when the baby is 2, 4, 6, 9, 12, 15 and 18 months of age; (2) family planning discussions and referral, as appropriate, to a birth control clinic; (3) instruction in parenting skills; and (4) informal parenting education through videotapes, slides and discussions with nurse practitioners or trained volunteers.

The effectiveness of the program was assessed in a study in which 243 African-American teen mothers at an urban teaching hospital were randomly assigned to either the treatment (i.e., program) or control group. Compared to members of the control group, who received traditional well-baby services, program participants experienced significantly fewer repeat pregnancies and were more likely to obtain full immunization for their newborns. Mothers who continued attending the clinic for the duration of the program also reduced their use of the emergency room for routine infant medical care.

Focus

☐ Primary pregnancy prevention
☑ Secondary pregnancy prevention
☐ STD/HIV/AIDS prevention

Original Site

☐ School-based
☐ Community-based
☑ Clinic-based

Suitable for Use In

This program is suitable for use in hospital- or community-based pediatrics clinics, providing that medical and counseling services are available.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach

☐ Contraceptive Access
☑ Contraceptive Education
☑ Life Option Enhancement
☐ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age, Gender	The field study involved 243 first-time mothers under 18 years of age (avg. age=16.5 years).
Race/ Ethnicity	100% African-American

Program Components

☐ Adult Involvement
☑ Case Management
☑ Group Discussion (in waiting room)
☐ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☐ Role Play
☑ Video
☑ Other Informal parenting education through one-on-one discussions and educational materials

Program Length

In the field study, participants received services from delivery until their children reached 18 months of age.

Staffing Requirement/ Training

In the field study, the clinic was staffed by a pediatrician, a master's level nurse practitioner and a social worker, who all worked part time. A half-time master's level nurse practitioner served as program director. Trained volunteers were recruited to serve as informal parent educators in the clinic waiting room.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

This intervention is designed both to meet the multiple, interrelated needs of teenage mothers and their infants, who are at risk for long-term physical, psychological and socioeconomic difficulties, and to prevent repeat pregnancies. Located within a teen baby clinic, the program combines regular well-baby check-ups with reproductive health counseling, referrals for contraception and parenting education, modeling and support. In addition, staff members encourage the young mothers to return to school and reduce their use of hospital emergency services for routine infant care. Services are delivered by a team of medical and social service providers.

A field study and evaluation of the program were conducted with 243 unwed teenage African-American mothers receiving Medicaid. Program services were provided in a well-baby clinic located in a teaching hospital in Philadelphia, PA. Funding for development and evaluation of the intervention was provided by the Robert Wood Johnson Foundation.

Rationale for the Program

This program was developed in recognition of the complex challenges and everyday needs of unmarried teenage mothers and their infants. In particular, babies born to teenage mothers frequently have low birth weights and are at increased risk for developmental delays, mental retardation and other neurological disorders. In addition, young mothers frequently drop out of school and have few financial resources with which to support their children. With low levels of educational and vocational achievement, the mothers' opportunities may be severely limited over time.

The program developers also found that teenage mothers may not understand the importance of regular health care. Often they miss appointments for routine well-baby check-ups but visit the emergency room when their infants display only minor symptoms.

A review of services provided to teenage mothers in other countries suggests that counseling, health care and education programs may improve the well-being of teenage mothers and their infants. For this reason, the program developers created a comprehensive program combining traditional well-baby care with special counseling and educational services tailored to the needs of teenage mothers (e.g., reproductive health counseling, parenting education). Regular clinic visits are used as an opportunity to reinforce program messages about health care, educational achievement and parenting skills. Preventing repeat pregnancy is also emphasized as an explicit goal of the intervention.

Program Objectives

The multiple components of the *Health Care Program for First-Time Adolescent Mothers and their Infants* are designed to meet the following objectives:

(1) to reduce the repeat pregnancy rate among adolescent mothers;

(2) to increase mothers' attendance in school after giving birth;

(3) to increase the proportion of mothers who obtain full immunization for their infants; and

(4) to reduce teenage mothers' use of the emergency room for routine infant care.

Program Overview

The *Health Care Program for First-Time Adolescent Mothers and their Infants* provides a wide range of basic information on topics essential for the well-being of new mothers and their infants. To accommodate the needs and lifestyles of participants, the program is designed to be flexible, and numerous opportunities are provided for informal education and discussion. Critical features of the intervention are highlighted below; examples are provided from the original field study of the intervention.

Setting

The program is designed to be implemented in a hospital clinic. During the field study, all activities took place in the teen baby clinic in which the participating mothers had agreed to bring their newborn for well-infant care.

Staffing

The team of staff members should include a pediatrician, a social worker and a nurse practitioner, all of whom are knowledgeable about adolescent development and comfortable working with teen mothers. For the field study, in which 120 mothers participated, one pediatrician, one social worker and one master's level nurse practitioner were all employed on a part-time basis. One additional nurse practitioner staffed the program half-time; in addition to providing nursing care, she served as director and oversaw all administrative tasks. In the waiting room, trained volunteers were also available to discuss and model parenting skills with the young mothers.

To minimize the costs of services, the pediatrician and nurse practitioners may alternate in providing care. It is recommended that the social worker speak with all participants during their two-week visit to the clinic and thereafter, by referral from other staff members. Relying on trained volunteers—rather than nurse practitioners— to provide informal educational activities in the waiting room will also help to reduce personnel costs.

Regular Well-Baby Visits

Well-baby care should be provided in accordance with guidelines issued by the American Academy of Pediatrics. That is, mothers and their infants are scheduled for routine check-ups at the clinic, first at two weeks postpartum, and then when the baby has reached 2, 4, 6, 9, 12, 15 and 18 months of age.

Special Care

In addition to routine well-baby care, the following services should be delivered to each participating teen. During the field study, these services were incorporated into the mothers' regular clinic visits.

Repeat Pregnancy Prevention

At the two-week clinic visit, the social worker interviews each mother to determine her understanding of contraception and family planning. When appropriate, the social worker may counsel and educate the young woman and refer her to a nearby birth control clinic. During subsequent clinic visits, the pediatrician and nurse practitioners continue to inquire about the mother's use of family planning; if appropriate, they may suggest that she speak again with the social worker or visit a reproductive health clinic.

Parenting Education

Parenting education should begin at the two-week clinic visit and continue for the duration of the program. At the two-week visit, the social worker discusses and models good parenting skills by demonstrating how to properly hold and feed a baby. The mother is also encouraged to ask any questions she may have about health care, growth and development and parenting.

Additional, informal education can take place in the waiting room. During the field study of the intervention, for example, trained volunteers and nurse practitioners were available to discuss health care and parenting skills on a one-to-one basis with mothers in the clinic waiting room. They answered questions and concerns, modeled skills and provided counseling and support. Also available were numerous educational brochures providing information on a variety of parenting issues, including proper nutrition for mother and baby, choosing a contraceptive method, selecting a car seat, installing a smoke detector and taking an infant's temperature. Sample brochures from the field study are included in the PASHA program package. You may wish to use some of these materials or obtain comparable ones from appropriate agencies in your local community (e.g., Planned Parenthood, County Health Department).

As part of the parenting education component, staff members discouraged mothers from visiting the emergency room when their infants showed only minor symptoms. They also showed the women how to take care of minor health problems, such as diaper rash and runny noses.

Encouragement for School Re-enrollment

Along with pregnancy prevention, support for school participation begins during the two-week clinic visit and continues for the duration of the program. All staff members—including the pediatrician, nurse practitioners and social worker—ask about the young woman's educational plans and encourage her to return to school. They may also assist her in making the necessary arrangements and researching options for child care.

Full Infant Immunization

During clinic visits, staff members should remind mothers about the importance of obtaining full immunization for their infants. In the field study of the program, participants were also provided with copies of their infants' immunization records, free of charge, no matter how many times they lost these papers. Staff explained that the records would be required when enrolling a child in day care, Head Start, pre-school or kindergarten. Information about the US Public Health Service's recommended immunization guidelines was also provided via a one-page chart.

Additional Supports

Program staff should anticipate that mothers may have difficulty keeping their scheduled appointments. To encourage continued participation in the program, it is recommended that staff members contact mothers who miss a scheduled appointment, either by calling or sending a letter. During the field study, for example, reminders were sent each week for a six-week period following the first clinic visit; for subsequent appointments, the reminders continued for eight weeks. In addition, reminder calls for all visits were attempted the day before each scheduled visit. Sample reminder notices from the field study are included in the program package.

Program Materials: Replicating or Adopting *Health Care Program for First-Time Adolescent Mothers and their Infants*

The *Health Care Program for First-Time Adolescent Mothers and their Infants* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of this book. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package. The package includes the following materials needed to implement this program in your medical clinic.

Sample Educational Pamphlets

These sample informational pamphlets cover a wide range of parenting topics, such as health, nutrition, accident prevention and family planning. Invite mothers to look through them while they are waiting to meet with clinic staff. During the field study of the program, educational videos were also available to participants in the waiting room; if you choose to use videos, you will need a TV and VCR as well.

Sample Reminder Notices

During the field study, reminder notices were used to remind participants about scheduled appointments. You can use these samples as a guide in developing your own materials.

Schedule of Services

The schedule of services lists all of the services in the *Health Care Program for First-Time Adolescent Mothers and their Infants*. Keep the card handy as you plan and implement your program.

Immunization Update

The immunization update packet summarizes the recommended immunization schedule issued by the Advisory Committee on Immunization Practices of the US Public Health Services. Have your staff review this information with participants during regular well-baby visits.

Nursery Songs

During the field study of the program, a booklet of nursery songs was given to all program participants. It includes familiar nursery rhymes that mothers can sing with their infants.

How to Implement the Program

Before your program begins, staff should take part in a training session that is designed to: (1) introduce the framework for the intervention and the services that will be provided; (2) provide basic information about adolescent psychosocial and cognitive development, adolescent sexuality and the challenges faced by teen mothers; and (3) convey basic strategies for communicating with, and providing support to, adolescent mothers.

Be sure to allow sufficient time to recruit and train a group of volunteer parent educators who will be comfortable working with teenage mothers. Training should cover the same material as described above; it should also provide opportunities for the volunteer educators to practice modeling parenting skills and supporting and communicating with teens. You may want to invite a psychologist, health educator or social worker who can share his/her expertise and experience working with adolescent mothers.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the *Health-Care Program for First-Time Adolescent Mothers and their Infants* was investigated in an 18-month study conducted with 243 mothers attending a hospital clinic in Philadelphia, Pennsylvania. The young women were randomly assigned either to: (1) the treatment group, who took part in a comprehensive program providing well-baby care, parenting education, family planning counseling and referrals, and received support for continuing their education; or (2) the control group, who received traditional well-baby care only, without any additional services. To compare the two groups, a variety of measures were recorded for the mothers and their babies, from the time of enrollment in the study, through the young women's regular visits to the clinic, and until the infant reached 18 months of age. Using medical records, these measures could be recorded regardless of whether the mother and her child continued attending the clinic for the duration of the study.

Evaluation Questions

The researchers hypothesized that members of the treatment group would show the following outcomes, compared to their control group peers receiving traditional well-baby services only:

(1) a higher rate of clinic attendance;

(2) a higher rate of school enrollment;

(3) a higher immunization rate for their babies;

(4) less frequent use of the emergency room for routine infant care; and

(5) a lower repeat pregnancy rate.

Data Collection Procedures

Teenage mothers were recruited for the study during their postpartum stay in a participating hospital. The researchers invited young women who: (1) were 17 years of age or under; (2) had decided to keep their child; and (3) could provide consent as emancipated minors. Those who agreed to participate and met the eligibility criteria were randomly assigned to either the treatment (N=120) or control group (N=123).

At recruitment, the researchers measured a number of demographic variables, both by reviewing patient charts and by asking participants directly. Subsequently, they relied on chart reviews to measure the mothers' clinic attendance and infant immunization rates. At a final, 18-month interview, participants were asked whether they had experienced a repeat pregnancy or returned to school; the latter measure was verified using school records, and immunization data were verified using infant charts.

Research Sample

Of the 300 teens recruited for the study, 58 (18%) refused to participate, and 29 (9%) were lost due to administrative reasons at the hospital. Thus, the final sample included 243 mothers, all of whom were African-American and receiving Medicaid. Additionally, most of the teens had not been pregnant previously, had experienced no complications during delivery and had received about five months of prenatal care. Although many teens dropped out of the two groups over the duration of the study, through the 18-month follow-up interview the researchers were able to gather complete data for 91% of the original research sample.

Evaluation Results

Clinic Attendance

Beginning with the first scheduled clinic visit two weeks postpartum, and continuing for the duration of the study, program participants showed a significantly higher clinic attendance rate than their control group peers. At the two-week visit, for example, 92% of the treatment group, versus 76% of the control group, kept their appointments ($p=.002$). By the final appointment, 18 months postpartum, 40% of program participants continued to attend the clinic; in contrast, only 18% of their control group peers did so. Although the dropout rate was high for both groups, it was nearly twice as great within the control group.

School Enrollment

At the conclusion of the study, the researchers found no significant difference between the two groups' rate of school enrollment. Regardless of whether school records or self-reports were used, the researchers found that approximately 50% of the mothers in both groups had re-enrolled in school following the birth of their child.

Infant Immunization Status

By the conclusion of the study, mothers in the treatment group were significantly more likely than their control group peers to have obtained full immunization for their infants ($p<.02$). Within the treatment group, 33% of the infants (37 of the 113 infants for whom data were available) had received full immunization; in contrast, within the control group, full immunization was recorded for 18% of infants (20 of the 111 for whom data were available). The researchers found no differences in the immunization rates recorded among infants whose mothers had dropped out from either intervention; however, when they focused on "continued attenders," the difference approached significance ($p=.058$). That is, 60% of treatment group infants whose mothers continued attending the clinic for the duration of the study had received full immunization, versus 36% of this subset of control group infants.

Emergency Room Use

The researchers noted that both groups of mothers used the emergency room to a high degree. They found that 76% of program participants (85 of the 110 mothers for whom data were available) visited the emergency room at least once during the course of the study. Among control group mothers, 85% (96 of 113 mothers for whom data were available) did so. In a chi-square test, this difference was not significant at the p=.05 level. However, the two groups of continued attenders did differ significantly on this measure (p<.03), with 81% of program participants (39 of 48 mothers) and 100% of the control group (22 of 22 mothers) making at least one visit to the emergency room during the course of the study.

Repeat Pregnancy

Teens who took part in the *Health Care Program for First-Time Adolescent Mothers and their Infants* were significantly less likely to have experienced a repeat pregnancy by the conclusion of the study (p<.003). In particular, at the 18-month interview, repeat pregnancies were reported by 13 of the 108 program participants (12%) for whom complete data were available. Within the comparison group, in contrast, the repeat pregnancy rate was 28% (32 of the 113 mothers for whom complete data were available). In subsequent analyses, the researchers determined that the repeat pregnancy rates did not differ significantly for teens who remained in their respective programs, but did differ between those teens who had dropped out (p=.02). That is, 15% of mothers who dropped out of the treatment group experienced a repeat pregnancy (9 pregnancies, N=60), while 32% of dropouts from the control group did so (29 pregnancies, N=91).

Across the sample, the researchers found that teens who remained in the study for only the two-week or two-month visits had a higher repeat pregnancy rate than those who continued attending the clinic for at least six months. Moreover, within the treatment group, both continued attenders and dropouts who were followed through the 18-month assessment were half as likely to experience a repeat pregnancy rate as their corresponding control group peers.

Summary

At the conclusion of the 18-month study of the *Health Care Program for First-Time Adolescent Mothers and their Infants*, program participants showed a number of positive outcomes, relative to their control group peers. Overall, participation in the program's comprehensive set of education, counseling and support services for teen mothers was associated with significantly higher clinic attendance and higher rates of full infant immunization, as compared to participation only in routine well-baby care. On measures of emergency room use, significantly fewer visits were made by program participants, but only within the subset of teens who continued attending the clinic for the duration of the study. The program appeared to have no impact on school enrollment, with more than half of the mothers in both the treatment and control groups returning to school.

The researchers found that program participants were significantly less likely to have experienced a repeat pregnancy at the 18-month follow-up than were their control group peers. Assuming that each birth to a teenage parent costs the public $15,620 (as calculated in 1986), and the intervention prevented 19 pregnancies (as calculated by the researchers), the program saved $296,780 in public funds. It should also be noted that mothers who attended *either* the treatment or control clinic for at least six months were more likely than dropouts to avoid a repeat pregnancy. Thus, it appeared that involvement in a special well-baby program was itself helpful in preventing a repeat pregnancy during adolescence.

Within both the treatment and control groups, large numbers of mothers dropped out of the study. Yet, the researchers noted that it is not uncommon for teenage mothers who are poor to drop out of special education and service programs. They suggested that future interventions might aim to involve the teen's entire family, to improve knowledge about family planning and to change the young women's attitudes about the future.

Evaluation Materials for *A Health Care Program for First-Time Adolescent Mothers and their Infants*

In addition to the program materials described in an earlier section, the PASHA program package includes four evaluation resources: the *Original Evaluation Instruments*, the *Minimum Evaluation Data Set for Care Programs (MEDS)* and the *Prevention Minimum Evaluation Data Set (PMEDS)*, and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in its new sites, with new groups of teens.

Original Evaluation Materials

Initial interview. This survey includes questions about the mother's health during pregnancy and delivery, academic and family background, relationship with the father and future aspirations, including schooling.

Final (18-month) interview. Questions in this interview probe the teen's family background, experiences at school, employment history, feelings about the baby, patterns of sexual intercourse and contraception and her relationship with the baby's father. Additional measures assess the baby's health and the mother's use of the clinic over the course of the study. During the original evaluation of the program, the mother was also asked to sign a release form authorizing the researchers to review her school records.

MEDS and PMEDS

The *Minimum Evaluation Data Set for Care Programs (MEDS)* is a generic instrument that has been specially designed for evaluating the effectiveness of secondary pregnancy prevention programs, such as the *A Health Care Program for First-Time Adolescent Mothers and their* Infants. MEDS is self-administered and includes questions addressing teens' family background, health and contraceptive behaviors, pregnancy outcomes, infant status and exposure to program activities.

In the program package you will also find an instrument that can be used to evaluate a variety of primary pregnancy and STD/HIV/AIDS prevention programs for teens. Like *MEDS*, the *Prevention Minimum Evaluation Data Set (PMEDS)* is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors and attitudes. Some of these measures may be helpful for evaluating the *QHC Teenage Program*.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

10

Queens Hospital Center's Teenage Program

An Adolescent Pregnancy Prevention Program

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Bibliography

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Program Abstract

Title

Queens Hospital Center's Teenage Program

Summary

Based upon the premise that a teen's first pregnancy may stem from underlying unmet needs, this program provides a comprehensive set of services including medical care, psychosocial support and education to the adolescent, her partner and her family. This approach emphasizes early intervention, beginning during pregnancy. For the duration of the intervention, each patient and her infant remain with a team of providers: an obstetrician-gynecologist, pediatrician, social worker and health educator. The program also has a physician/practitioner "on call" 24 hours a day. Reproductive health and family life education classes are offered to the patient, her partner and her family. In an effort to prevent repeat pregnancies and STDs, the program encourages the teen's partner to participate in education, support and counseling activities. Access to other services is enhanced by the program's location in a multi-service center which houses many social service agencies.

A field study of the intervention was conducted in Queens, New York with 498 adolescents and their infants. Program participants were more likely to attend clinics regularly, to use contraception more frequently and to attend and graduate high school than were teen mothers in a comparison group. Both the participating teen mothers and their infants experienced better health outcomes than those in the comparison group. The investigators also found a significantly reduced repeat pregnancy rate among participating mothers. Only nine percent of the adolescent mothers in the program had a repeat pregnancy, as compared to seventy percent of the comparison group. Moreover, the teenage mothers' repeat pregnancy rate declined with each successive year of program participation.

Focus	☐ Primary pregnancy prevention	☑ Secondary pregnancy prevention	☐ STD/HIV/AIDS prevention
Original Site	☐ School-based	☑ Community-based	☑ Clinic-based

Suitable for Use In

This program is suitable for use in hospital- or community-based clinics, providing that comprehensive medical and counseling services are available.

Approach

☑ Abstinence
☑ Behavioral Skills Development
☑ Community Outreach
☑ Contraceptive Access
☑ Contraceptive Education
☑ Life Option Enhancement
☐ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age	The field study included 498 first-time mothers, who were all under age 20 when their child was born (avg. age at delivery=17 years).
Race/ Ethnicity	The ethnic make-up of the program clients was 90% African-American, 6% Hispanic and 4% other (including Asian, Native American, East Indian & Caucasian).

Program Components

☑ Adult Involvement
☑ Case Management
☑ Group Discussion
☐ Lectures
☑ Peer Counseling/Instruction
☐ Public Service Announcements
☐ Role Play
☐ Video
☑ Other partner and family involvement

Program Length

During the field study, participants were eligible to receive services from pregnancy until they reached their twentieth birthday. Family life education classes were held on a bi-weekly basis for the duration of the program.

Staffing Requirement/ Training

Your team of providers should include physicians, nurses, social workers, health educators and additional staff as needed. In the field study, which served 498 mothers, the staff consisted of a team of physicians (drawn from a rotating pool of 2 pediatricians and 1 or 2 ob-gyns), 3 registered nurses and 6 nurses' aides, 6 social workers, 2 male counselors, 2 health educators, 1 coordinating manager, and 6 to 8 clerical assistants. Clergy were also available as needed. In

1984, the program also began recruiting peer counselors to offer presentations in the waiting room.

During the field study, the coordinating manager held regular weekly meetings to train the staff. Additionally, each group of service providers (e.g., physicians, social workers, health educators) held their own meetings to discuss training issues particular to their specialty.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

The *Queens Hospital Center's (QHC) Teenage Program* was developed in 1982 to respond to the high adolescent pregnancy rates in the South Jamaica community in Queens, New York. Recognizing that many of the causes and adverse consequences of teenage pregnancy are functions of socioeconomic, rather than medical or age factors, the program attempts to address underlying social and economic problems faced by adolescent mothers and their families.

The program adopts a team approach to respond to the many needs of pregnant and parenting teens. Upon enrollment in the program, the pregnant adolescent is assigned a team of professionals for the duration of her care. Each team—drawn from the program's interdisciplinary staff of obstetrician-gynecologists, pediatricians, social workers and health educators—tailors the broad array of program services to the specific needs of each adolescent. In addition to medical services for the mother and her child, the program provides contraceptive and STD (including HIV/AIDS) counseling, contraception and HIV testing, as well as ongoing education in reproductive health and family life for the patient, her partner and family. Vocational and educational assistance, supportive counseling and social work services are also provided to the mother and her partner. Indeed, the program actively involves the teen's partner in education, support and counseling, particularly with respect to prevention of repeat pregnancy and sexually transmitted diseases.

A field study of the program was conducted with a diverse group of adolescents and their infants enrolled in Queens Hospital Center's mother-baby family planning clinic. Between 1982 and 1989, 498 adolescent mothers participated in the program. The program was established by Queens Hospital Center's affiliation of the Long Island Jewish Medical Center's Departments of Obstetrics & Gynecology and Community Medicine and Ambulatory Care. Funding was provided by New York State's Department of Health Offices of Adolescent Pregnancy and Family Planning, as well as by New York City's Health and Hospital Corporations Division to Reduce Low Birth Weight Infants.

Theoretical Framework

The development of *Queens Hospital Center's Teenage Program* was based upon the premise that the causes and many of the adverse consequences of teenage pregnancy reflect an ongoing cycle of unmet needs, including the need for parenting education and economic, psychological and emotional support.

The developers postulated that a teen's first pregnancy may be a "red flag" signifying the underlying problem: an upbringing marked by unmet basic needs. If not addressed, a teen mother risks experiencing a repeat pregnancy with more serious consequences than those of the first pregnancy (e.g., prematurity, low birth weight and intrauterine growth retardation). Therefore, to successfully prevent repeat adolescent pregnancy and its negative consequences, it is essential to fully address the needs of adolescent mothers.

Program Goals

The overall aims of the program are:

- to reduce the teenage pregnancy rate (including repeat pregnancies, whether ending in live birth or termination);
- to improve maternal and infant health outcomes; and
- to assist participants in making positive choices for their reproductive health and for their adult lives.

Program Objectives

The *Queens Hospital Center's Teenage Program* seeks to:

- provide adolescent mothers and their partners with health care information regarding prevention of unwanted pregnancies, sexually transmitted diseases and HIV/AIDS;
- treat and counsel adolescents for pregnancy, sexually transmitted diseases and HIV/AIDS;
- enable teens to become more responsible and self-sufficient by staying in school and learning marketable skills;
- increase adolescent mothers' return to school;
- increase the participation of pregnant teenagers in preparing for the birth of their children and in obtaining care for their infants;
- involve the partners and families of the teenage mothers in the complete care of teenage mothers and their children;
- discuss with teenage mothers such options as a foster home or adoption; and
- encourage abstinence.

Program Components

Recruitment

Pregnant adolescents should automatically be referred to the program when they visit your hospital or clinic for prenatal care. In addition, have program staff and other hospital personnel recruit patients through brochure dissemination and other activities. In the field study of the program, for example, referrals were provided by family and friends of the pregnant teens, as well as by local clergy. One of the program developers also visited local high schools to familiarize teachers, administrators and students with the services available through the *QHC Teenage Program*.

Continuity of Care

Upon entry into the program, each teen is seen by a social worker for an intake interview and then assigned a health care provider. To ensure continuity of care, this same provider should meet with the teen at all subsequent visits. A team consisting of an obstetrician-gynecologist, a pediatrician, a social worker and a health educator oversees and directs the care of each patient from the prenatal period throughout the mother's participation in the program.

Accessibility

In the field study of the program, several features enhanced participants' access to services. The program's location in a multi-service center put teens in close proximity to many agencies offering a range of services in areas such as housing, nutrition and day care. In addition, the center itself was convenient to bus lines.

In 1986, the program began offering evening clinic hours (4:00 - 8:00 p.m.) two days a week, allowing teens to visit after school using their bus passes. A physician/ practitioner 24-hour "on call" system provided access to services at any time. Day care was also available during the teens' visits to the center.

Staffing

Providing the constellation of services offered by the *QHC Teenage Program* requires an interdisciplinary staff committed to a team approach in serving adolescent mothers and their children. In the field study, which served 498 mothers and their children, the staff included a team of physicians (drawn from a rotating pool of 2 pediatricians and 1 or 2 ob-gyns), 3 registered nurses and 6 nurses' aides, 6 social workers, 2 male counselors, 2 health educators and 1 coordinating manager. Clergy were also available as needed. In 1984, the program also began recruiting peer counselors to offer presentations in the waiting room. Finally, the program was served by approximately 6 to 8 clerical staff.

Services

The *QHC Teenage Program* provides adolescent mothers, their children, their partners and their families with a comprehensive set of services, as explained below. In the field study, all services were provided in the program's multi-service center. However, a number of participants continued attending regular high school programs during pregnancy and postpartum.

Sex, Birth Control and Parenting Education

The main educational component of the program provides all male and female participants with sex and birth control education. Reproductive and family life education are taught in ongoing bi-weekly meetings, led by a registered nurse, physician or health educator, and involving the patient, her partner and her family. During pregnancy, teens participate in childbirth preparation and Lamaze classes led by registered nurses or other hospital staff.

In the field study of the program, parenting education was offered as well. Social workers conducted workshops designed to educate male partners of adolescent mothers on questions of paternity and responsibility. They also discussed with each participant options such as foster home placement and adoption.

Complete Medical and Follow-Up Care for Mother and Child

Obstetrical and postpartum care is offered by a staff of physicians, nurse practitioners, physician's assistants, social workers and a program administrator. Attending obstetricians supervise prenatal and postpartum care. In the field study of the program, pregnant teens delivered at the Queens Hospital Center's labor and delivery unit. Intrapartum care was provided by resident physicians with attending supervision. All services were provided at the Queens Hospital Center's facilities. Over the duration of the field study, these services included well-woman care, internal medicine, family planning, and a range of specialized services.

Infant care was provided in accordance with the American Academy of Pediatrics protocols.

The program follows standard protocols for every aspect of medical care, including intake, preeclampsia, amniocentesis and referrals. These protocols do not specify how much time should be spent on any services—in the field study, providers were allowed to devote as much time as needed to complete the service.

HIV Counseling, Testing and Education.

In the original field study, HIV-related services were integrated into the regular bi-weekly family life education classes. Additional services were provided on an individual basis, as needed, by the physicians and/or social workers. When appropriate, the young women's partners were also included.

Vocational and Educational Assistance

In the field study, program staff—primarily the social workers—worked closely with local organizations providing vocational services to ensure that each of the participants had the opportunity to receive vocational training, job training and job placement services. Program participants also received educational assistance to complete high school or to receive their GED. The male counselors provided educational and vocational assistance to partners.

Supportive Counseling and Social Work Services

Psychological and social service counseling and guidance should be provided by the social workers on your program staff. In the field study, counseling began during the teen's first visit and was provided thereafter as needed. Each teen was assigned to a team so that she could establish close relationships with her service providers. In the event that the teen needed specialized assistance that went beyond the team's expertise, the staff referred the adolescent to appropriate community agencies and served as a liaison and facilitator to insure that the required services were provided.

Presentations by Peer Counselors

In the field study, peer counselors were selected from teenagers in the community and from among program clients. They received training to insure that they interacted with the participants in a supportive and knowledgeable manner. Peer counselors provided waiting room presentations in the form of plays written by them. Their role was to provide adolescents with information on abstinence, birth control, relationships, HIV/AIDS and other adolescent issues. They also conducted workshops in schools, churches and health fairs in the community. For their work, the peer counselors received stipends.

Program Materials: Replicating or Adapting *Queens Hospital Center's Teenage Program*

Educational Pamphlets

The *Queens Hospital Center's Teenage Program* can be obtained from the Program Archive on Sexuality, Health & Adolescence. See the Order Form at the back of the book. The package includes a collection of educational pamphlets which cover a wide range of topics, such as health, nutrition, family planning, and STD prevention. Invite your teens to look through these materials while they are waiting to meet with clinic staff. During the field study of the program, educational videos were also available to participants in the waiting room; if you choose to use videos, you will need a TV and VCR as well. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Handbook for Service Providers

The PASHA program package also includes a handbook for program staff. The handbook contains: (1) an overview of services provided in the *Queens Health Center's Teenage Program*; (2) Recommendations for Preventive Pediatric Health Care; and (3) Recommended Childhood Immunization Schedule. Keep these materials handy as you plan and implement your program.

How to Implement the Program

Community Outreach

The success of a multi-faceted program such as *Queens Hospital Center's Teenage Program* depends in large part on your ability to integrate the program into your community. It is essential to identify community resources and enlist community support. Residents, leaders in hospital medicine, church representatives, social workers, teachers, educational administrators and local media can all be involved in this effort. For this reason, the program director should begin by outlining how the program can best gain local acceptance, what the local needs are, how to enter the community and how to establish trust and support in the community. A good strategy will enable the program director to build the kinds of partnerships that are necessary to implement a comprehensive, multifaceted intervention such as the *Queens Hospital Center's Teenage Program*.

In the field study of the program, health fairs, workshops, seminars and lectures to churches, schools and community agencies all proved to be successful strategies for contacting the target population. The following provides a brief overview of community outreach activities used in the field study of the program. These activities can serve as starting points for your own implementation.

Raising Public Awareness

It is important to focus some effort on public awareness of the program in order to establish credibility and acceptance. Increase the visibility of your program through newspaper articles. Report on the program's location and its accessibility to public transportation and help inform young people who need the medical, social, vocational, housing and educational services you will be providing. Public announcements on the radio and television, in church and community bulletins, at commercial cinemas and the local sites of the world wide web may be good resources for "getting out the word" about your program.

Community Workshops

Another way to get the whole community involved is to offer informative workshops on the services provided in the program, and how issues of adolescent pregnancy are affecting the community, what residents can do to help, etc. The health educators and social workers on your staff can help to educate and inform your community about the benefits and services your program provides. For your own intervention, these workshops may also provide the opportunity to identify existing community resources which provide some of the services you want to offer.

Training

In the field study of the program, regular weekly meetings provided opportunities to educate staff about discussing family planning and contraception, HIV prevention and adolescent sexuality with program participants. Over the course of the program, training focused on additional issues that emerged in teens' lives, including domestic violence, postpartum depression and educational development.

In addition, each group of professionals (e.g., social workers, physicians) held their own staff meetings to discuss service or training issues particular to their specialty. The social workers met on a bi-weekly basis, and the physicians convened once each month.

Peer counselors also received training from program staff to develop skills in communicating family life information and ideas to adolescent mothers.

Coordination

In the field study, the coordinating manager used the weekly staff meetings to ensure smooth program functioning and to resolve any conflicts among staff. In addition, the meetings provided an opportunity to discuss findings from quality assurance visits (see below) along with strategies to address deficiencies, inconsistencies and other concerns about service.

Protocols

Program staff followed all of the standard American College of Gynecologists and American Academy of Pediatrics protocols (e.g., for prenatal and well-baby care and immunization schedules). No special protocols were developed for the program.

Although no specialized charts or forms were developed, staff kept extensive notes documenting the services provided to teens over the duration of the program. These notes were included in the medical records for each participant.

In the original field study, strict quality assurance protocols were put in place for the duration of the program. Official site visits were conducted regularly by the Queens Health Center, Department of Health and all granting agencies. Selected files were inspected for accuracy and completeness. Files were also monitored more frequently by program administrators.

Financing Medical Care

Current changes in public and private financing and delivery of health care services will pose challenges to any program providing comprehensive medical care, especially to low-income populations. For example, teens must now be enrolled in the managed care plan of which the Queens Hospital Center is a member in order to have program services covered by Medicaid. If a teen who is enrolled in another plan wishes to receive program services, program staff provide instructions on how to switch plans.

Beginning in 1994 (after the field study), the program could no longer provide certain services on site because of fiscal constraints. For example, males are now referred to other agencies for treatment of STDs. This has disrupted patients' relationships with program staff and makes patient follow-up more difficult.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the *Queens Hospital Center's Teenage Program* was investigated in a study of adolescent mothers and their newborns attending the mother-baby family planning clinic from 1982 to 1989. The study compared a group of teen mothers enrolled in the *Queens Hospital Center's Teenage Program* housed at the multi-service center with a comparison group of pregnant and parenting adolescents who received care at the Queens Hospital Center's Adult Obstetric Clinic from 1980-1981 (before the program's inception) and who continued to receive care with their newborns at the hospital's adult family planning and pediatrics clinics through 1989 or until they reached age 20.

Evaluation Questions

The evaluation of the *Queens Hospital Center's (QHC) Teenage Program* examined the following questions.

(1) Did participation in the *QHC Teenage Program* increase utilization of health care services by teen mothers and their children?

(2) Did participation in the *QHC Teenage Program* improve maternal and infant health?

(3) Did participation in the *QHC Teenage Program* improve teens' educational and vocational status?

(4) Did participation in the *QHC Teenage Program* increase teen mothers' use of contraceptives?

(5) Did participation in the *QHC Teenage Program* decrease the rate of repeat pregnancy among teen mothers?

(6) Did any of these outcomes change with prolonged exposure to the program?

Recruitment Procedures

A Department of Health Office at the intervention and comparison sites assisted in tracking pregnant patients. From 1980 to 1981 all patients who were seen for prenatal care were examined at the Queens Hospital Center's Adult Obstetrics and Gynecology Clinic. Between 1982 and 1986, all pregnant teenagers were automatically referred to the adolescent program. In addition, program staff and other hospital personnel recruited patients through brochure dissemination and other activities. Young women were eligible if they were under the age of 20 at delivery. Criteria for exclusion from the study included any pre-existing hypertension; diabetes; cardiac, renal, endocrinologic or neurologic disease; multiple gestation or known drug abuse.

Quality Control

There was no significant difference in the quality of medical care received by teens in the intervention and comparison groups. Medical and nursing protocols were uniform for each clinic and compiled by Queens Hospital Center's Departments of Obstetrics and Gynecology, Community Medicine and Ambulatory Care and Nursing. A Quality Assurance Committee was responsible for each site's records. The Queens Hospital Center's personnel department's standards for hiring qualified health care professionals remained consistent from 1980 to 1986. Intrapartum care was provided to both groups by resident physicians with attending supervision at the Queens Hospital Center's labor and delivery unit.

Data Collection Procedures

The data were retrospectively abstracted from outpatient and inpatient medical charts prior to July 1985 and prospectively collected from July 1985 onwards.

To assess questions relating to maternal and fetal health outcomes, researchers examined numerous prenatal, intrapartum and postpartum factors, including services received and behavioral influences, as well as clinical outcome variables. These data were recorded by clinicians in the medical charts of the teens and their infants.

From the social workers' charts the researchers obtained data regarding the student and occupational status of the patient; contraceptive use; and subsequent pregnancy, including pregnancy resolution during the patient's adolescence.

Sample

Adolescents in the sample were defined as those under 20 years of age. The age of teens in both the intervention and comparison groups ranged from 13 and 19 years. The intervention group consisted of 498 adolescents who were enrolled for prenatal care at Queens Hospital Center's adolescent pregnancy program between 1982 and 1986. They received care with their newborns until their twentieth birthday.

The comparison group consisted of 91 adolescents who received care at the Queens Hospital Center's adult prenatal clinic from 1980 to 1981, before the program began. Individuals in the comparison group continued to receive care with their newborns at the hospital's adult family planning and pediatrics clinics through 1989, or until they reached age 20. The mean age for both groups at delivery was 17. Less than 5% of individuals in both the intervention and comparison groups were lost to follow-up.

There was no difference between adolescents in the intervention and comparison groups with respect to age, socioeconomic status, completed years of school, prior poor obstetrical outcome or employment status of head of household. The facilities used by the intervention and comparison teens are about three miles apart, both located in neighborhoods characterized by high drug use and crime, as well as a high incidence of adverse health outcomes such as low birth weight and neonatal death.

As in virtually every clinical study, there were missing observations for a small number of participants. In this study 85% of the comparison group and 91% of the intervention group had a complete set of data. However, there were large differences between the two groups on the variances calculated for many outcome measures. The evaluator corrected for this result by employing a formula that decreased the degrees of freedom to produce meaningful results.

Evaluation Results

The results of the study indicate that the *Queens Hospital Center's (QHC) Teenage Program* had significant positive effects on teen mothers and their children. Moreover, many of the outcomes improved with each successive year of program participation.

Utilization of Health Care Services

Patients in the *QHC Teenage Program* entered care earlier and averaged more prenatal visits per trimester of care than comparison patients. Over 75% of the intervention group regularly attended the program's mother-baby clinic, compared to 18% of the comparison group attending the hospital's regular adult gynecology and pediatrics clinics ($p \leq 0.0001$). Furthermore, with each subsequent year of the program, a greater proportion of the intervention group attended the program. By 1989, 87% of this group did so.

Maternal and Infant Health Outcomes

There were many positive effects measured for the health of both the mother and the child. Compared to their peers in the comparison group, program participants showed lower indices of maternal morbidity ($p<0.0001$), including lower incidence of premature labor, deliveries closer to term and less infection and anemia during labor. Babies born to program patients displayed significantly less distress and weighed more than the newborns of the comparison patients ($p<0.001$). Subsequent maternal morbidity was lower among the intervention group (18% vs. 36%, $p<.0001$), as was subsequent infant morbidity ($p<.001$). Mothers in the intervention group were also more likely to breastfeed their infants for at least three months than were members of the comparison group (21% vs. 1%, $p<.0001$).

Educational and Occupational Status

Participation in the *QHC Teenage Program* also had positive effects on the adolescent mother's educational and occupational status. More teens in the intervention group attended school on a regular basis than did their comparison group peers (77% vs. 38%, $p<0.0001$). Not only did school attendance increase with each year of the program, but by 1989 over 95% of the teens in the intervention group who had regularly attended school had graduated from high school, earned a high school graduate equivalency degree or were within six months of graduation from one of these programs. Those in the intervention group sought and maintained employment more often and more consistently than did teens in the comparison group (48% vs. 22%, $p<0.0001$).

Contraceptive Use

Contraceptive use was more frequent among program participants (85% vs. 22%, $p<0.0001$). By 1989, over 96% of program patients used some form of contraception on a regular basis. This also improved for each year of program participation.

Repeat Pregnancy

The repeat pregnancy rate was lower in the intervention group with 9% becoming pregnant versus 70% in the comparison group.

Pregnancy resolution differed between the groups as well. Among these teens who experienced a repeat pregnancy, 6% of the intervention group and 34% in the comparison group chose to terminate their pregnancies ($p<0.0001$). For all years of the program, repeat pregnancy, whether ending in live birth or termination, declined significantly with each successive year ($p \leq .0001$).

Summary

The results of the evaluation indicate that a comprehensive service program can effectively increase contraceptive use and prevent repeat pregnancy among a group of adolescents considered to be at very high risk—teen mothers from urban, low-income neighborhoods. Teen mothers who participated in the *Queens Hospital Center's Teenage Program* also showed other positive outcomes compared to a group of teen mothers who received routine care. Among program participants, the researchers measured an increased use of recommended health care services by both the mothers and their children, from the prenatal period through the first few years of the child's life. Similarly, mothers and children demonstrated better health outcomes for the duration of the study. In addition, program participation had a positive effect on educational and vocational achievement, with participating teen mothers significantly more likely to attend high school and to seek and maintain employment.

Researchers attribute the success of the program to the concerted efforts to maintain contact with the patient for the duration of the program. The evidence that scores improved over the duration of the program indicates that over time, the program gained acceptance by teenagers in the targeted area.

Evaluation Materials for *Queens Hospital Center's Teenage Program*

The researchers did not create any evaluation instruments for assessing the effectiveness of this program. Instead, they gathered evaluation data from patients' medical charts, including the services received by mothers and their infants, as well as clinical outcomes. In addition, from the notes kept by social workers the researchers obtained data regarding the student and occupational status of the patient, contraceptive use and subsequent pregnancy, including pregnancy resolution during the patient's adolescence. You may want to follow a similar approach in evaluating your own implementation of this program.

In addition, the PASHA program package includes three resources to help you begin evaluating your program, should you choose to do so: the *Minimum Evaluation Data Set for Care Programs (MEDS)*, the *Prevention Minimum Evaluation Data Set (PMEDS)* and the *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

MEDS and PMEDS

The *Minimum Evaluation Data Set for Care Programs (MEDS)* is a generic instrument that has been specially designed for evaluating the effectiveness of secondary pregnancy prevention programs, such as the *Queens Hospital Center's Teenage Program*. You may want to consider this instrument as an alternative to relying on medical records and notes, as described above. *MEDS* is self-administered and includes questions addressing teens' family background, health and contraceptive behaviors, pregnancy outcomes, infant status and exposure to program activities.

In the program package you will also find an instrument that can be used to evaluate a variety of primary pregnancy and STD/HIV/AIDS prevention programs for teens. Like *MEDS*, the *Prevention Minimum Evaluation Data Set (PMEDS)* is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors and attitudes. Some of these measures may be helpful for evaluating the *QHC Teenage Program*.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

11

Adolescents Living Safely: AIDS Awareness, Attitudes and Actions

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Program Abstract

Title

Adolescents Living Safely: AIDS Awareness, Attitudes and Actions

Summary

Originally designed to meet the comprehensive needs of runaway youths, this program combines 20 small group discussion sessions with one session of private counseling. The group meetings provide general instruction about HIV/AIDS through video, role plays and other activities in which youth both review professionally produced educational materials and create their own skits, commercials and videos. Several exercises encourage the teens to think about the ways in which high-risk sexual behaviors might prevent them from accomplishing all that they hope in their lives. Participants also practice strategies for coping with high-risk situations involving drug and alcohol use. The counseling component is designed to identify individual needs and provide youth with appropriate resources.

A field study of the program was conducted at two shelters serving predominantly Hispanic and African-American runaways between 11 and 18 years of age in New York City. The 20-session sequence was offered continuously over a two-year period, but youth joined the program at various points, and their levels of participation varied. For teens who attended at least fifteen sessions, the high-risk pattern of sexual behavior (50% or less condom use combined with 10 or more sexual encounters and/or sex with 3 or more partners) dropped in frequency from 20% to zero over a six-month period. In addition, consistent condom use rose from 33% to 63% at the six-month evaluation. At the two-year follow-up assessment, program effects remained strongest for male and African-American participants.

Focus

☐ Primary pregnancy prevention
☐ Secondary pregnancy prevention
☑ STD/HIV/AIDS prevention

Original Site

☐ School-based
☑ Community-based
☐ Clinic-based

Suitable for Use In

This program can be implemented in a variety of community-based settings serving high-risk youths, especially runaways, providing that case management and counseling services are available. It is also appropriate for residential treatment programs.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☑ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☑ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age, Gender	The original sample included 78 runaway youths, ages 11 to 18 (avg.=15.5 years); 64% were female.
Race/ Ethnicity	63% African-American, 22% Latino, 8% White, 7% other

Program Components

☐ Adult Involvement
☑ Case Management
☑ Group Discussion
☐ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☑ Role Play
☑ Video
☑ Other video and art workshops

Program Length

In addition to ongoing counseling and case management services, the full intervention includes 20 group sessions, held over a three-week period. Each session is designed to last 90 to 120 minutes.

Staffing Requirement/ Training

Group sessions (with approximately 6 to 10 youths) are facilitated by two leaders, preferably one male and one female, who are from diverse backgrounds. Participating teens may also split into male and female groups, with same-sex leaders, as warranted. Other professional staff (e.g., lawyers, vocational counselors) should be on call to provide necessary services.

Training should include cognitive and behavioral risk reduction strategies (e.g., turning negative into self-affirming thoughts, avoiding risky situations), coping with clinical crises and group process skills. Although staff may be familiar with social support and therapy groups, a structured, cognitive-based intervention may at first be challenging for them. It is important to discuss the ways in which this program differs from group therapy.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence. An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

Adolescents Living Safely: AIDS Awareness, Attitudes and Actions is an HIV risk-reduction program originally designed to meet the comprehensive needs of runaway youths, who are at high risk for STD/HIV/AIDS. Based on a cognitive-behavioral model that has guided several previous health promotion efforts with adolescents, the program encourages skill building and self-efficacy in an environment of peer support. The importance of safe sex is emphasized throughout all of the lessons. Please note that the PASHA collection includes a companion program, *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens*. The curriculum for this companion program includes additional sessions focused on the particular needs of teens who identify as gay, lesbian or bisexual, as well as youth who are unsure of their sexual orientation.

Twenty group discussion sessions form the core of the *Adolescents Living Safely* program. In these sessions youth receive basic information about HIV/AIDS and learn strategies for practicing safe sex. In addition, participants complete exercises in sexual assertion, refusal skills, partner negotiation, self-management, problem-solving, risk recognition and correct condom and dental dam use. Finally, a personal counseling session is included to ensure that the individual needs of each youth are addressed.

The program was developed by researchers at Columbia University and the HIV Center for Clinical and Behavioral Studies and Division of Child Psychiatry at the New York State Psychiatric Institute. Between 1988 and 1990 a field study was conducted with runaway teens recruited from two publicly funded shelters in New York City. The National Institute of Mental Health, the National Institute on Drug Abuse and the William T. Grant Foundation all provided funding for the study.

Theoretical Framework

Adolescents Living Safely is guided by a cognitive-behavioral approach to health promotion, which relies heavily on Social Learning Theory.

Bandura's Social Learning Theory elaborates the processes through which intentions can be translated into behavioral change among teens. Bandura asserts that learning occurs through practice and observation of social models; it is mediated by internal beliefs about one's ability to succeed, anticipated rewards and consequences of one's actions and others' evaluation of one's performance. *Adolescents Living Safely* emphasizes the importance of practicing, observing and modeling as vehicles for learning new skills and improving old ones.

The cognitive-behavioral method yields a practical and theoretically grounded approach for helping adolescents that can be tailored to suit the needs of the client population, institutional setting and community. The program aims to increase adolescents' awareness and understanding of their own feelings before trying to increase knowledge, attitudes or behavioral skills. If teens cannot talk about and understand their own feelings, they will be unable to communicate with potential partners about safer sexual practices.

Program Model

Adolescents Living Safely is based on the following model of human behavior.

People will continue to behave in a certain way if:

(1) they expect something good to result from their behavior;

(2) something that they want does occur;

(3) something good happens often; and

(4) any negative consequences occur a long time after the positive ones.

People will behave effectively in their best interests if:

(1) they know what is in their best interest;

(2) they have the skills;

(3) they have opportunities to learn skills in many ways: through observing, imitating and practicing;

(4) they believe they have effective tools and can use them effectively; and

(5) they fit into the environment in which they live and the environment supports them.

The program developers expanded on this model of behavior to develop a set of principles for the *Adolescents Living Safely* sessions.

Program Goals

The overall aim of the program is to reduce high-risk sexual behaviors among adolescents. Specifically, the intervention is designed to help participants:

- abstain from sex and unsafe behavior if they have not yet had sexual intercourse;
- use a condom or dental dam when engaging in sexual activities where an exchange of body fluids is possible;
- screen potential partners and avoid sex with those who are risky or of questionable HIV status; and
- refrain from getting high on alcohol or drugs before having sex.

Program Objectives

To meet the goal of reducing sexually risky behavior, the program developers defined ten behavioral objectives for teens who participate in the *Adolescents Living Safely* program:

(1) to acquire general knowledge about HIV/AIDS: definitions, consequences, routes of transmission, high-risk behaviors, prevention strategies and testing;

(2) to believe they can get AIDS, they can prevent themselves from getting AIDS and they can change their own behavior;

(3) to label, assess and control the intensity of their feelings in high-risk situations;

(4) to reward themselves with positive feedback for thought and behavior patterns that are likely to reduce the risk of infection;

(5) to use self-talk to guide themselves successfully through situations that are sexually risky;

(6) to identify and change dysfunctional thoughts;

(7) to solve interpersonal problems through clarifying goals, identifying risks, costs and opportunities, evaluating alternative strategies for fixing the situation, trying out alternatives and analyzing success;

(8) to express their needs assertively, say "No" in risky situations and communicate with confidence;

(9) to determine the advantages and disadvantages of being tested for HIV; and

(10) to identify community resources and use these resources as needed, particularly free condoms, dental dams and health and mental health care.

Hypothesized Outcomes

It is hypothesized that an intensive community-based intervention program, accompanied by case management, counseling services and health care, will enable youths to:

- decrease their sexual risk acts, such as unprotected anal, vaginal or oral sex; and
- increase their use of condoms and dental dams when engaging in sexual activity.

Program Content

Adolescents Living Safely sessions include four main components.

(1) **Knowledge.** Facts about HIV may be communicated through two types of activities. First, teenagers participate in video and art workshops to develop soap opera dramatizations, public service announcements, commercials and raps about HIV prevention. In the original field study, they also reviewed commercial HIV prevention videos.

(2) **Coping skills.** Participants receive training to address unrealistic expectations about their ability to cope in high-risk situations. They learn to identify personal cues or triggers that place them at potential risk for HIV transmission and to identify and practice behavioral and cognitive coping responses to such situations.

(3) **Health care.** In the field study of the program, participants made at least one visit to a community-based agency providing vocational and educational counseling, recreational opportunities and referrals for comprehensive health and mental health care and legal aid.

(4) **Individual barriers.** Through private counseling sessions, participants review their individual barriers to safer sex, especially negative attitudes.

Program Schedule

Adolescents Living Safely consists of twenty 90-120-minute group meetings that are held approximately four times a week over a three- to five-week period. All meetings are facilitated by two trained professionals. In addition, an individual counseling session is held with each participant.

Each group session shares the following seven elements.

(1) Positive behaviors are reinforced, particularly by giving teens small tokens of colored paper as a symbol of their contributions to the group discussion.

(2) Participants are encouraged to assess, monitor and label their feelings through the use of a Feeling Thermometer.

(3) Talk is used as a strategy to diminish group members' anxiety concerning taboo topics.

(4) After group leaders model effective coping skills, participants practice through role plays.

(5) Self-esteem is promoted through positive interaction and esteem-building exercises. Self-efficacy is promoted by enabling the teens to demonstrate newly acquired skills and receive feedback from group leaders.

(6) Concern is continually raised regarding unsafe sexual behaviors and involvement in risky situations and with risky partners.

(7) Group cohesion is established through active participation and appreciation of each person's contributions.

Brief overviews for the sessions are provided below.

Description of Program Sessions

SESSION 1: What Will *Adolescents Living Safely* Do for Me?

The leaders and participants introduce themselves at the start of this session. The topic of safer sex is explored by inviting teens to consider sexual behaviors on a continuum, from low-risk to high-risk activities. After discussing reasons why people engage in unsafe acts, even if they know better, the group identifies strategies that can help people practice safe sex. The session continues with a brief review of the goals and ground rules of the program and discussion of the first homework assignment. Throughout the program, homework activities are used to carry over into the teens' real lives the material presented during group discussions. Finally, the leaders encourage participants to recognize at the end of each session fellow group members whose contributions they have appreciated.

211

SESSION 2: How to Recognize My Feelings

This session is designed to help participants identify their personal levels of comfort and discomfort in social situations. After a discussion of the importance of feelings to safer sexual behavior, the group engages in a series of exercises using the Feeling Thermometer. This thermometer, printed on a sheet of paper, shows a scale ranging from 0 to 100. Throughout the program sessions, teens are asked to "take their temperature" by assessing their position on the scale—from 0, indicating that one feels very, very comfortable, to 100, representing a high level of discomfort. Breathing exercises for relaxation in tense situations are also introduced, both here and later, during many of the sessions. The facilitators end the session by inviting participants to express their appreciation for their peers' contributions to the meeting.

SESSION 3: How Serious Is the Threat to Me?

This lesson provides teens with a clearer understanding of the threats posed by HIV and AIDS, especially death. In one exercise, teens pretend that they are at a party. Each guest wears a name tag, and some of the tags have small flowers on them. During a brief mingling period, participants are asked to introduce themselves to one another and decide which guests they would want to have sex with. When the mingling ends, the facilitators explain that guests whose name tags have flowers are HIV-positive. If, in real life, the teens had had sex with such people, they would have put themselves at risk for HIV infection. A second exercise is designed to encourage participants to think of death in relation to their hopes and dreams for the future— i.e., what they hope to accomplish before they die. For homework, participants are asked to think of one step they can take toward their personal lifetime goals.

SESSION 4: What Do I Need to Know about HIV/AIDS?

Basic facts and terminology about HIV/AIDS are discussed in this session. In the original field study, the teens viewed a video describing the AIDS Antibody Test and discussed reasons why it might be important to take the test. You may want to hold a similar discussion with your own teens. Toward the end of the session, participants identify myths and misunderstandings they believe their peers have about AIDS; for homework, each person is asked to educate two friends about the virus.

SESSION 5: What Are My High-Risk Situations?

Learning how to recognize and avoid high-risk situations is the goal of this session. Through role plays, discussions and games, the group leaders help participants identify the particular situations they are likely to face. Additional exercises encourage group members to think of ways they can get out of such situations and argue against commonly-used rationalizations for unsafe activities.

SESSION 6: When Is My Sexual Behavior Safe?

To address participants' confusion about the safety of particular activities, this session focuses on sex as a continuum of behaviors. In one exercise, teens are asked to think about the safety level of various friends' sexual practices; each is evaluated as "safe," "possibly safe" or "definitely unsafe." During the next exercise, group members look at their own personal behaviors, again considering the safety of their actions. At the close of the session, a group profile of safe sex behaviors is compiled.

SESSION 7: How to Use a Condom and Dental Dam

The proper use of condoms and dental dams is taught during this session, and humor is recommended as a tension-reducing strategy. The facilitators emphasize the importance of latex condoms, along with appropriate lubricants and spermicides. As a group, participants first practice putting a condom on their hand or a penile model (e.g., banana, zucchini) and then practice using a dental dam. For homework, participants are asked to locate a local store where they can purchase condoms.

SESSION 8: How to Spread the Word about Safer Sex

At the start of the meeting, the group leaders emphasize the importance of condoms by explaining that participants will be asked to show that they are carrying condoms with them at all future sessions. Participants divide into three teams and each is asked to create a media message (e.g., TV commercial, rap or newscast) about ways to protect oneself from HIV. Each team spends about 20 minutes creating their skit, then performs the piece for the rest of the group. For homework, participants are asked to evaluate messages about HIV that they encounter as they watch TV, listen to the radio or read a newspaper or magazine.

SESSION 9: Tell Me More about Sex

Through role-play exercises and group discussion the group explores feelings about sexual activity, sex education and communication in intimate relationships. During the second half of the session, the group splits into male and female teams, and each meets privately with a same-sex leader. Participants are asked to write any questions they have about sex on an index card, and the leader addresses them. In the field study of the program, each facilitator was given a guide for discussing questions commonly asked by teens. You may want to put together such a guide for your own group leaders.

SESSION 10: How to Cope with Trouble

This session introduces participants to strategies for coping in difficult situations. In a role-play exercise, participants illustrate each of eight possible strategies, from "seek support" to "escape the scene." The group leaders emphasize problem solving as one of the best coping techniques. Using a problem analysis form, participants learn how to define, assess and constructively confront a problem situation. Techniques for relaxing in such situations are rehearsed.

SESSION 11: Coping with My Use of Drugs and Alcohol

The relationship of drug and alcohol use to HIV infection is explored in this session. Through observation, role play and discussion, participants evaluate the effects of drugs and alcohol on their lives and especially, the risk level of their behaviors. An exercise critiquing the behaviors of various actors involved in risky situations shows participants how to gain a sense of control over their lives. An additional exercise helps participants identify the emotional triggers that lead them to get high. The leaders help the youth to see that they have choices other than using drugs. Finally, the group leaders demonstrate the proper procedure for cleaning IV drug needles with bleach.

SESSION 12: Dealing with Pressures to Use Drugs/Alcohol

Through a series of exercises on communication skills, gaining confidence, role-play scenarios and "I statements," participants learn how to deliver effective refusals and requests in risky situations. Participants also review previously-learned coping techniques for taking control when pressured to use drugs or engage in unsafe sex. These activities are designed to enhance teens' self-confidence in coping with high-risk situations, which is also linked to their self-esteem and self-efficacy.

SESSION 13: How to Handle Thoughts that Don't Help Me

Shifting to cognitive strategies for promoting safer sex, the group leaders help participants distinguish self-defeating from self-enhancing thoughts. Working with a partner, each teen is asked to write down self-defeating thoughts that they use a lot in their lives; next to each thought they are asked to devise a self-supporting thought that could be used instead. The group continues this exercise together, focusing on thoughts that occur during sexual situations. For homework, participants are asked to catch themselves in the middle of unhelpful thoughts, yell "Stop!" to themselves, and come up with self-affirming thoughts.

SESSION 14: Visiting a Person with AIDS

To reduce teens' stereotypes about people with AIDS, this session is designed to enable students to meet individuals with the virus. The facilitators encourage participants to ask questions, show respect and share their own feelings. Typically, the visit includes an informal meal, which serves to promote feelings of intimacy and reduce myths about catching HIV through normal human contact. The visit is followed by a debriefing session in which group members can discuss their feelings and reactions to the meeting.

SESSION 15: Should I Be Tested for HIV?

The HIV Antibody Test Sheet is used to engage participants in a discussion of the test and the meaning of the results, whether positive or negative. The facilitators give group members a list of local agencies, first where they could get tested and second, where they could receive treatment. Working in pairs, the teens then explore their own possible reactions to a positive test result. Finally, group members raise and explore the question of whether they should be tested.

SESSION 16: Using Self-Talk to Practice Safer Sex

The group leaders promote the idea that teens can feel better about themselves by giving themselves compliments and rewards. An exercise encourages group members to practice using self-talk, or talking to themselves, in tough situations. Finally, the group splits up by sex to participate in an activity that involves rewriting negative self-talk in a rap song.

SESSION 17: How to Choose Safe Friends

This session is designed to help participants assess the risks posed by their friends and sexual partners. In an introductory exercise, the teens learn that they often do not know which friends are HIV-positive. This exercise highlights two points: first, that you cannot tell if someone is HIV positive just by looking at them, and second, it is not who the person is, but what they do, that leads to HIV infection. For these reasons, the leaders emphasize, safe sex is essential. In a second exercise boys and girls meet separately to create lists of the qualities they like in partners. Strategies for starting and ending relationships are also explored, and the group practices screening partners through discussion and role playing.

SESSION 18: Looking over a Community Resource

The goal of this session is to introduce group members to community case management agencies that provide services to runaway youth. A list of other local resources should also be given to participants.

A PERSONAL COUNSELING SESSION

In addition to the group discussion sessions, each teen has an individual counseling session with a trained professional. The counselor first determines whether the adolescent is sexually active and then designs a plan to overcome barriers to practicing safer sex or maintaining abstinence. The counselor also addresses any questions the teen has regarding sex and HIV/AIDS.

SESSION 19: Making a Soap Opera on HIV/AIDS

To integrate the lessons of the previous sessions, the group creates an original soap opera on HIV/AIDS. The leaders first encourage the group to devise a story and choose script writers, a director, camera men or women, actors and editors. Once the story is complete, the skit is performed, videotaped and viewed. In the field study of the program, the teens particularly enjoyed creating and acting out humorous scripts.

SESSION 20: The End and the Beginning

During the final session, group members are asked to share their feelings about the program. Members explore their hopes for the future by creating postcards that they would mail to their peers in five years. A relaxation technique is used to help group members feel good as they offer their good-byes.

Program Materials: Replicating or Adapting *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions*

The *Adolescents Living Safely* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence. See the Order Form at the back of the book. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package. The following program materials are included.

Curriculum Materials

Adolescents Living Safely: AIDS Awareness, Attitudes and Actions Curriculum Manual. This comprehensive manual describes the rationale and methods for the program. Step-by-step instructions for facilitating each session are included, along with masters of all program handouts and guidelines for implementation.

Adolescents Living Safely Activity Packets. Accompanying the *Adolescents Living Safely Curriculum Manual* are activity packets that contain the activity cards and handout masters for sixteen of the twenty program sessions. The cards and handouts are clearly labeled with the session number and the name of the activity or handout. Sessions 14, 18, 19, and 20 do not require accompanying session packets.

Additional Materials

The PASHA program package provides all of the materials (mentioned above) needed to implement *Adolescents Living Safely* in your community. However, additional equipment is required for some of the sessions, including a video recorder, a TV and VCR, photocopier, a chalkboard or flip chart and markers, pencils, index cards and small tokens cut from construction paper. You will also need supplies for the condom skills demonstration and training session, such as condoms and dental dams, lubricant, and penis models, (e.g., cucumbers or bananas). These items can be obtained at a local pharmacy, grocery or drug store.

How to Implement the Program

Lesson Preparation

Prior to the first lesson, staff members should read the entire *Adolescents Living Safely Curriculum Manual* thoroughly and view the program videotape. The *Manual* contains a series of tips and guidelines for implementing the program and working with at-risk youth. For example, the following tips are suggested for creating productive group sessions.

(1) Reward thoroughly any observable positive behavior.

(2) Be supportive.

(3) Give compliments.

(4) Be non-judgmental.

(5) Create a happy group.

(6) Encourage group cohesion.

(7) Model appropriate assertive behavior.

(8) Be firm.

(9) Illustrate points through modeling.

(10) Share personal experiences (not current hang-ups).

(11) Keep language simple.

(12) Encourage group members to share their own experiences.

(13) Build on strengths.

(14) Listen.

(15) Let the group members do the reacting, responding, thinking and analyzing.

(16) Be flexible.

(17) Keep trying. If one approach doesn't work, try another one.

Additional tips for handling problems that arise during the group sessions are provided in the program's *Curriculum Manual*.

Special Materials

In each session a Feeling Thermometer and small colored tokens are used with participants. The thermometer helps teens recognize, measure and appropriately express their feelings in a group setting. At various points during the discussion leaders will ask for volunteers to "take their temperature" on a paper scale. At the low end of the scale is 0, indicating that one feels very, very comfortable. A measure of 100 represents the other extreme, a high level of discomfort.

The tokens serve as symbols of one's appreciation for the contributions offered by a peer. The tokens are 2" square pieces of colored construction paper; a stack of these is given to each group member at the start of every session. When a participant does or says something that another person likes, agrees with, finds encouraging or causes him/her to think, the listener hands over a token and explains the reason for doing so.

Use of Two Co-leaders

It is recommended that two leaders, one male and one female, co-facilitate each session. At the beginning of the program, the co-leaders establish control by directing activities, setting the pace and insuring that participants maintain self-control. One leader should direct the activities while the other monitors the process, giving feedback and helping the group stay focused. These responsibilities can be rotated regularly. When the full group divides into male and female teams, same-sex leaders facilitate each team.

Having leaders briefly review lesson outlines, role-play scripts and checklists of activities and materials before the start of each session will help meetings flow smoothly.

Evaluating the Program

The Original Evaluation

Design

In a field trial, researchers compared the sexual and STD protective behaviors of *Adolescents Living Safely* participants to those of a comparison group of runaway teens.

The study was conducted between 1988 and 1990 at the only two publicly-funded shelters for runaway youths in New York City. At one shelter, volunteers were recruited into the *Adolescents Living Safely* program; at the second shelter, volunteers joined the comparison group. The comparison group received no intervention other than the usual counseling and informal education provided by staff. However, condoms were also available to this group.

All data were gathered with semi-structured interviews. Three interviews were held with each participant during the study period:

- Time 1: At the start of the intervention (pre-test);
- Time 2: Three months following the intervention (three-month follow-up); and
- Time 3: Six months following the intervention (six-month follow-up).

Additionally, the researchers re-contacted many of the participants for an additional follow-up assessment two years following the intervention.

Evaluation Questions

Three empirical questions guided the field study.

(1) Does participation in the *Adolescents Living Safely* program lead to lower rates of high-risk sex acts?

(2) Do program participants use STD protection more effectively than members of the comparison group?

(3) Do program participants show lower rates of sexual activity relative to their peers?

Data Collection Procedures

After providing informed consent, each participant completed the baseline interview—a semi-structured protocol assessing sexual activities during the prior three months. Youth participating in the *Adolescents Living Safely* program then joined the discussion groups and completed additional interviews at three- and six-month intervals. Comparison group members were re-contacted for follow-up assessments at the appropriate times. Participants received $2.00 for completion of the baseline interview, and $20 to $25 for each of the follow-up assessments.

The three interviews were identical in format. Questions were combined to form three measures of sexual risk.

(1) Abstinence: having no sexual partners in the past three months.

(2) High-risk pattern of sexual behavior: infrequent condom use (use during less than 50% of sexual encounters) combined with ten or more sexual encounters and/or three or more sexual partners.

(3) Consistent condom use: use of a condom during every instance of oral, vaginal or anal sex.

Because few encounters with same-sex partners were reported, only heterosexual activities were considered in the analyses. Demographic measures were also recorded, including age, gender, ethnicity, length of time since living at home, number of days at the shelter and number of group sessions attended (for program participants only).

Sample

The researchers observed that teens moved in and out of the shelters as other housing arrangements became available, and the levels of participation varied. The final sample comprised 78 *Adolescents Living Safely* participants and 67 comparison group members. The youth ranged in age from 11 to 18 years (average=15.5 years); 64% were female and the majority were African-American or Hispanic. None of the teens had symptoms of HIV infection or AIDS at the time of the study.

At the start of the investigation, the researchers found no significant differences in patterns of sexual behavior between program participants and members of the comparison group. Also, the teens who stayed longer at the shelters did not differ from others on any of the demographic or behavioral measures. At both shelters, follow-up contact was more likely to be maintained with females than with males.

Evaluation Results

The impact of the program was found to vary with the number of discussion sessions attended. Fifteen sessions emerged as a significant "cutting point." That is, the 21 youths who attended at least 15 sessions showed significant improvements on two of the three behavioral outcomes, as explained below.

High-Risk Sexual Behavior

For program participants attending at least 15 group discussion sessions, the incidence of high-risk sexual behaviors dropped from 20% at baseline to zero at the three- and six-month follow-up assessments.

Condom Use

For runaways participating in 15 or more sessions, condom use rose from 33% at baseline to 57% at three months and 63% at six months after the intervention.

Abstinence

The program appeared to have no significant impact on abstinence among teens. Regardless of the level of participation in the *Adolescents Living Safely* program, no differences were found in self-reported abstinence between program and comparison group teens.

In addition, at the three- and six-month follow-up assessments, the researchers found no significant differences on any of the outcome measures as a function of youths' ethnicity, age, gender or time of entry into the program.

When contacted again for a two-year follow-up assessment, program participants continued to show significant reductions in HIV risk-related behaviors. However, different patterns emerged at this point across ethnic group and gender. Overall, program participation was most effective for African-American teens and males.

Summary

The empirical results demonstrate that *Adolescents Living Safely* can produce significant, positive changes in the sexual behaviors of runaway adolescents. Compared to a comparison group of their peers, the 21 teens who attended at least 15 group discussion sessions showed more effective use of condoms and a reduction in the number of high-risk sex acts at the three- and six-month follow-up assessments. These effects remained significant even two years following the intervention.

On the other hand, it should be noted that no change was observed in the levels of abstinence recorded among program participants.

Although *Adolescents Living Safely* did not discourage sexual activity, it did promote safer sexual practices among this group of high-risk youth. Additionally, it is possible that self-selection played a role in the behavioral outcomes. The researchers found that the 21 youths who attended at least 15 sessions did not differ from the rest of the sample on demographic or sexual risk behavior measures at baseline. Still, these youth may have differed in other significant ways from their peers who participated less regularly in the *Adolescents Living Safely* program.

Evaluation Materials for *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments*, the *Prevention Minimum Evaluation Data Set (PMEDS)* and the *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

In the original field study, the evaluators used a comprehensive psychosexual assessment developed by the New York State Psychiatric Institute and Columbia University. The four instruments included in this assessment are described below.

The *Attitudes & Values Survey* probes teens' feelings about sexuality and STD/HIV/AIDS-related preventive behaviors, as well as their perceptions of peer norms regarding sexual involvement. A second set of questions asks about recent life events the respondent may have experienced, such as moving to a new home or having a family member die. Finally, there are questions probing teens' psychological adjustment and knowledge about HIV transmission and prevention. In the original field study, this instrument was used only at the follow-up assessments.

The *Baseline Interview* covers such domains as psychosexual milestones, lifetime homosexual and heterosexual histories, sexual behavior in the previous three months, how respondents screen sexual partners and sexual imagery and orientation in the past three months. Please note that the questions were developed for high-risk adolescents and may not be suitable for all populations. Although the entire interview should be given to teens at the Time 1 (pre-test) assessment, only the final three sections— focusing on teens' sexual behaviors and practices in the past three months— are used during the follow-up assessments.

The *Demographic Measures* instrument examines the teen's family background, religious affiliation, reasons for leaving home, current residential and financial situation, school experiences, physical and mental health and conduct problems, if any. A few items assess the teen's awareness of, and access to, reproductive health care and STD protection. An additional set of measures investigate whether the respondent knows anyone who is HIV positive. In the original field study, this instrument was used at the Time 1 assessment.

The *Tracking Information* interview gathers background data about your teens. This instrument only needs to be administered at the start of your study.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Adolescents Living Safely: AIDS Awareness, Attitudes, and Actions*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

12

Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens

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Rotheram-Borus, M. J., Reid, H. & Rosario, M. (1994). Factors mediating changes in sexual HIV risk behaviors among gay and bi-sexual male adolescents. *American Journal of Public Health*, 84(12), 1938-1946.

Program Abstract

Title

Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens

Summary

This program, one of two *Adolescents Living Safely* interventions in the PASHA collection, is specially designed to provide education, social and medical services and peer support to gay, lesbian and bisexual adolescents between 14 and 19 years of age. It combines case management, comprehensive health care and risk assessment counseling with 25 small group discussion sessions. During the group sessions, transmission and prevention of HIV/AIDS are investigated through video and art workshops in which teens review commercially available videos and create their own materials, such as soap operas and raps on HIV/AIDS and safer sex. Participants learn how to cope with high-risk situations, such as when the HIV status of a potential partner is unknown. The sessions also address such topics as coming out, stigma and self-acceptance, which are particularly important to teens confronting sexual identity issues. The case management and counseling components are designed to identify individual needs and provide participants with appropriate services (e.g., legal, medical, vocational).

A field study of the intervention was conducted with 138 males at a community-based agency serving gay youth in New York City. The impact of the program was found to vary over time and across racial/ethnic groups. Among sexually active participants (70% of the sample), African-American and White teens showed a significant decrease in unprotected anal intercourse at the three-month follow-up assessment; at six months the decrease was significant only among Whites. On measures of unprotected oral intercourse, White and Hispanic youths engaged in fewer risk acts through the twelve-month assessment; among African-Americans, the decrease was maintained until six months following the intervention.

Focus	☐ Primary pregnancy prevention	☐ Secondary pregnancy prevention	☑ STD/HIV/AIDS prevention
Original Site	☐ School-based	☑ Community-based	☐ Clinic-based

Suitable for Use In

This program can be implemented in a variety of community-based and/or clinic-based programs serving youth at high risk for contracting HIV/AIDS, providing that case management and counseling services are available. This program is also suitable for implementation in residential drug treatment programs. Although it was field tested with a group of adolescent males, the curriculum has been designed for use with females, as well.

Approach

- ☐ Abstinence
- ☑ Behavioral Skills Development
- ☐ Community Outreach
- ☑ Contraceptive Access
- ☑ Contraceptive Education
- ☐ Life Option Enhancement
- ☑ Self-Efficacy/Self-Esteem
- ☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age, Gender	The original sample included 138 gay males, ages 14 to 19 years (avg.=16.7).
Race/ Ethnicity	51% Hispanic, 31% African-American, 12% White, 6% other.

Program Components

- ☐ Adult Involvement
- ☑ Case Management
- ☑ Group Discussion
- ☐ Lectures
- ☐ Peer Counseling/Instruction
- ☐ Public Service Announcements
- ☑ Role Play
- ☐ Video
- ☑ Other video and art workshops

Program Length

The full intervention consists of 25 group sessions in addition to regular counseling and case management services. It is recommended that two to four sessions be scheduled per week, over a seven to ten week period. Each session should last approximately 90 to 120 minutes.

Staffing Requirement/ Training

Group sessions (with approximately 10 youths) are facilitated by two leaders, selected for their sensitivity to issues of cultural and sexual diversity. Training should include cognitive-behavioral risk reduction strategies, coping with clinical crises and group process skills. Other professionals (e.g., lawyers, vocational counselors) should be on call to provide other specialized services as needed.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens is a comprehensive program developed to meet the needs of gay and bisexual male adolescents, who are at high risk for contracting the human immunodeficiency virus (HIV). Although it was originally implemented with gay and bisexual males, the curriculum is equally appropriate for use with lesbian and bisexual females. Additionally, there is a companion program in the PASHA collection that is suitable for use with a wide range of teens, *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions.*

The original program developers recognized that teens often know the safest alternatives for sexual situations, but they lack the social skills to implement their knowledge. Thus, in designing the *Adolescents Living Safely* curriculum, they adapted key components from programs that have been successful in changing sexual risk behaviors in runaways and adult gay men and in changing other adolescent health-risk behaviors. These components include: social skills training, behavioral self-management and group and social support from peers. Issues especially pertinent to gay, lesbian and bisexual teens (e.g., coming out, stigma, shame, self-acceptance) are covered as well. The program also addresses teenagers' needs for comprehensive health care.

A field study of the program was conducted with 138 gay and bisexual males, predominantly African-American and Hispanic. The study took place at the Hetrick Martin Institute, a community-based agency providing recreational and social services to gay youths in New York City. Grants from the National Institute for Mental Health, the National Institute on Drug Abuse and the William T. Grant Foundation provided support for the project.

Theoretical Framework

Adolescents Living Safely is guided by a cognitive-behavioral approach to health promotion, which relies heavily on Social Learning Theory.

Bandura's Social Learning Theory elaborates the processes through which intentions can be translated into behavioral change among teens. Bandura asserts that learning occurs through practice and observation of social models; it is mediated by internal beliefs about one's ability to succeed, anticipated rewards and consequences of one's actions and others' evaluation of one's performance. *Adolescents Living Safely* emphasizes the importance of practicing, observing and modeling as vehicles for learning new skills and improving old ones.

The cognitive-behavioral method yields a practical and theoretically grounded approach for helping adolescents that can be tailored to suit the needs of the client population, institutional setting and community. The program aims to increase adolescents' awareness and understanding of their own feelings before trying to increase knowledge, attitudes or behavioral skills. If teens cannot talk about and understand their own feelings, they will be unable to communicate with potential partners about safer sexual practices. Such self-understanding is particularly critical for teens confronting questions of sexual identity. Research reveals that youth who feel comfortable with their bisexuality or homosexuality are less likely to engage in risky social and sexual behaviors.

Program Model

Adolescents Living Safely is based on the following model of human behavior.

People will continue to behave in a certain way if:

(1) they expect something good to result from their behavior;

(2) something that they want does occur;

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(3) something good happens often; and

(4) any negative consequences occur a long time after the positive ones.

People will behave effectively in their best interests if:

(1) they know what is in their best interest;

(2) they have the skills;

(3) they have opportunities to learn skills in many ways: through observing, imitating and practicing;

(4) they believe they have effective tools and can use them effectively; and

(5) they fit into the environment in which they live and the environment supports them.

Program Goals

The overall aim of the program is to reduce high-risk behavior among adolescents. Specifically, the intervention is designed to help participants:

- abstain from sex and unsafe behavior if they have not yet had sexual intercourse;
- use a condom or dental dam when engaging in sexual activities where an exchange of body fluids is possible;
- screen potential partners and avoid sex with those who are risky or of questionable HIV status; and
- refrain from getting high on alcohol or drugs before having sex.

Educational Objectives

In addition, the program developers defined eleven educational objectives for teens who participate in the *Adolescents Living Safely* program:

(1) to acquire general knowledge about HIV/AIDS: definitions, consequences, routes of transmission, high-risk behaviors, prevention strategies and testing;

(2) to believe that they can get AIDS, they can prevent themselves from getting AIDS and they can change their own behavior;

(3) to label, assess and control the intensity of their feelings in high- risk situations;

(4) to reward themselves with positive feedback for thought and behavior patterns that are likely to reduce the risk of infection;

(5) to use self-talk to guide themselves successfully through situations that are sexually risky;

(6) to identify and change dysfunctional thoughts;

(7) to solve interpersonal problems through clarifying goals, identifying risks, costs and opportunities, evaluating alternative strategies for fixing the situation, trying out alternatives and analyzing success;

(8) to express their needs assertively, say "no" in risky situations and communicate with confidence;

(9) to determine the advantages and disadvantages of being tested for HIV;

(10) to identify community resources and use these resources as needed, particularly free condoms, dental dams and health and mental health care; and

(11) to deal with being gay, lesbian or bisexual by defining themselves positively, coming out to themselves and others, improving relationships with friends and lovers and coping with stigma.

Hypothesized Outcomes

It is hypothesized that this intensive, community-based intervention, accompanied by case management, counseling services and health care, will enable teens to:

- decrease their sexual risk acts, such as unprotected anal, vaginal or oral sex; and
- increase their use of condoms and dental dams when engaging in sexual activity.

Program Content

Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens sessions include five main components.

(1) **Knowledge.** Facts about HIV are communicated through two types of activities. First, teenagers participate in video and art workshops to develop soap opera dramatizations, public service announcements, commercials and raps about HIV prevention. Second, they review commercial HIV prevention videos.

(2) **Coping skills.** Participants receive training to address unrealistic expectations about their ability to cope in high-risk situations. They learn to identify personal cues or triggers that place them at potential risk for HIV transmission and to

identify and practice behavioral and cognitive coping responses to such situations.

(3) **Health care.** In the field study of the program, participants made at least one visit to a community-based agency providing vocational and educational counseling, recreational opportunities and referrals for comprehensive health and mental health care, as well as legal aid.

(4) **Individual barriers.** Through private counseling sessions, participants review their individual barriers to safer sex, especially negative attitudes.

(5) **Attitudes.** Participants and group leaders discuss prejudice against gays. It is believed that positive feelings and attitudes toward coming out may improve teens' attitudes toward safer sex.

Program Schedule

Adolescents Living Safely consists of 25 group sessions plus one individual counseling session. Each group session shares the following six strategies.

(1) Positive behaviors are reinforced, particularly by giving teens small tokens of colored paper as a symbol of their contributions to the group discussion.

(2) Participants are encouraged to assess, monitor and label their feelings through the use of a Feeling Thermometer. This thermometer, printed on a sheet of paper, shows a scale ranging from 0 to 100. Throughout the program sessions, teens are asked to "take their temperature" by assessing their position on the scale—from 0, indicating that one feels very, very comfortable, to 100, representing a high level of discomfort.

(3) Talk is used to diminish group members' anxiety concerning taboo topics.

(4) After group leaders model effective coping skills, participants practice through role plays.

(5) Concern is continually raised regarding unsafe sexual behaviors, involvement in risky situations and with risky partners.

(6) Group cohesion is established through active participation and appreciation of each person's contribution.

A comprehensive overview for the program sessions can be found in the *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens Curriculum Manual*. It provides background information on issues that place gay, lesbian and bisexual teens at risk of contracting HIV/AIDS. It also offers instructions and guidelines for program leaders. Brief overviews for the sessions appear below.

Description of Program Sessions

SESSION 1: What Will *Adolescents Living Safely* Do for Me?

The leaders and participants introduce themselves at the start of this session. The topic of safer sex is explored by inviting teens to consider sexual behaviors on a continuum, from low-risk to high-risk activities. After discussing reasons why people engage in unsafe acts, even if they know better, the group identifies strategies that can help people practice safe sex. The session continues with a brief review of the goals and ground rules of the program and discussion of the first homework assignment. Homework activities are used in all program sessions to link the curriculum material to teens' everyday experiences. Finally, the leaders encourage participants to recognize at the end of each session fellow group members whose contributions they have appreciated.

SESSION 2: What Is It Like Being a Gay or Lesbian Adolescent?

This lesson is designed to help participants confront negative stereotypes about gay and lesbian people and to begin to define positive identities for themselves. After exploring the concept of the "self," individuals are asked to share with the group their most outstanding quality. In the original field study of the program, two men and two women, chosen to represent positive role models of gay and lesbian identity, were invited to describe their lives. The group can also discuss famous gay and lesbian figures and their contributions to society. The facilitators end the session by inviting participants to express their appreciation for their peers' contributions to the meeting.

SESSION 3: Coming Out to Myself

To reinforce the lessons of the previous session, teens are invited to share with the group something brave that they have done. Then the focus shifts to a discussion of coming out, first to oneself and then to others. The leaders emphasize that self-acceptance is required before one can take the necessary steps to reduce one's risk of HIV infection (or if one is HIV positive, to lead a high-quality life). A series of exercises are used to help group members think about the complex feelings involved in coming out. In the original field study of the program, each participant was presented with a certificate "for being themselves."

SESSION 4: Coming Out to Others

The focus of this lesson is a step-by-step approach teens can use in coming out about their sexual identity to others. The model presents a series of questions prompting reflection about why one wants to come out and how to proceed. Exercises provide group members with practice in confronting reactions they may face from family and friends.

SESSION 5: How to Recognize My Feelings

This session is designed to help participants identify their personal levels of comfort and discomfort in social situations. After a discussion of the importance of feelings to safer sexual behavior, the group engages in a series of exercises using the feeling thermometer. Breathing exercises for relaxation in tense situations are also introduced; similar exercises will be used in several program sessions.

SESSION 6: How Serious Is the Threat to Me?

This lesson provides teens with a clearer understanding of the threats posed by HIV and AIDS, especially death. In one exercise, teens pretend that they are at a party. Each guest wears a name tag, and some of the tags have small flowers on them. During a brief mingling period, participants are asked to introduce themselves to one another and decide which guests they would want to have sex with. When the mingling ends, the facilitators explain that guests whose name tags have flowers are HIV-positive. If, in real life, the teens had decided to have sex with such people, they would put themselves at risk for HIV infection. A second exercise is designed to encourage participants to think of death in relation to their hopes and dreams for the future—what they hope to accomplish before they die. For homework, participants are asked to think of one step they can take toward their personal lifetime goals.

SESSION 7: What Do I Need to Know about HIV/AIDS?

Basic facts and terminology about HIV/AIDS are discussed in this session. In the original field study, the teens viewed a video describing the *AIDS Antibody Test* and discussed reasons why it might be important to take the test. You may want to hold a similar discussion with your own teens. Toward the end of the session, participants identify myths and misunderstandings they believe their peers have about AIDS; for homework, each teen is asked to educate two friends about the virus.

SESSION 8: What Are My High-Risk Situations?

Learning how to recognize and avoid high-risk situations is the goal of this session. Through role plays, discussions and games, the group leaders help participants identify the particular situations they are likely to face. Additional exercises encourage group members to think of ways they can get out of such situations without resorting to commonly-used rationalizations for unsafe activities.

SESSION 9: When Is My Sexual Behavior Safe?

To address participants' confusion about the safety of particular activities, this session focuses on sex as a continuum of behaviors. In one exercise teens are asked to think about the safety level of various friends' sexual practices; each is evaluated as "safe," "possibly safe" or "definitely unsafe." During the next exercise, group members look at their own personal behaviors, again considering the safety of their actions. At the close of the session a group profile of safe sex behaviors is compiled.

SESSION 10: How to Use a Condom and Dental Dam

The proper use of condoms and dental dams is taught during this session, and humor is recommended as a tension-reducing strategy. The facilitators emphasize the importance of latex condoms, along with appropriate lubricants and spermicide. As a group, participants first practice putting a condom on their hand or a penile model (e.g., banana, zucchini) and then practice using a dental dam. For homework, participants are asked to locate a local store where they can purchase condoms.

SESSION 11: How to Spread the Word about Safer Sex

At the start of the meeting, the group leaders emphasize the importance of condoms by explaining that participants will be asked to show that they are carrying condoms with them at all future sessions. Participants divide into three teams and each is asked to create a media message (e.g., TV commercial, rap or newscast) about ways to protect oneself from HIV. Each team spends about 20 minutes creating their skit, then performs the piece for the rest of the group. For homework, participants are asked to evaluate messages about HIV that they encounter as they watch TV, listen to the radio or read a newspaper or magazine.

SESSION 12: Tell Me More about Sex

Through role-play exercises and discussion, the group explores feelings about sexual activity, sex education and communication in intimate relationships. During the second half of the session, the group splits into male and female teams, and each meets privately with a same-sex leader. Participants are asked to write any questions they have about sex on an index card, and the leader addresses them. During the field study of the program, the leaders were given a booklet summarizing questions frequently asked by teens.

SESSION 13: How to Cope with Trouble

This session introduces participants to strategies for coping in difficult situations. In a role-play exercise, participants illustrate each of eight possible strategies, from "seek support" to "escape the scene." The group leaders emphasize problem solving as one of the best coping techniques. Using a problem analysis form, participants learn how to define, assess and constructively confront a problem situation. Techniques for relaxing in such situations are rehearsed.

SESSION 14: Coping With My Use of Drugs and Alcohol

The relationship of drug and alcohol use to HIV infection is explored in this session. Through observation, role play and discussion, participants evaluate the effects of drugs and alcohol on their lives and especially, the risk level of their behaviors. An exercise critiquing the behaviors of various actors involved in risky situations shows participants how to gain a sense of control over their lives. An additional exercise helps participants identify the emotional triggers that lead them to get high. Finally, the group leaders demonstrate the proper procedure for cleaning IV drug needles with bleach.

SESSION 15: Dealing with Pressures to Use Drugs/Alcohol

Through a series of exercises on communication skills, gaining confidence, role-play scenarios and "I statements," participants learn how to deliver effective refusals and requests in risky situations. Participants also review the previously-learned coping techniques for taking control when pressured to use drugs or engage in unsafe sex.

SESSION 16: Friends and Lovers

This lesson is based on the premise that experimentation and observation are key ways to learn about adult sexual and social relationships. In one exercise, participants identify group members they would like to know better. They introduce themselves and then report on their experiences. Techniques for starting conversation and coping with relationship issues are also discussed.

SESSION 17: How to Handle Thoughts that Don't Help Me

Shifting to cognitive strategies for promoting safer sex, the group leaders help participants distinguish self-defeating from self-enhancing thoughts. Working with a partner, each teen is asked to write down self-defeating thoughts that they use a lot in their lives; next to each thought they are asked to devise a self-supporting thought that could be used instead. The group continues this exercise together, focusing on thoughts that occur during sexual situations. For homework, participants are asked to catch themselves in the middle of unhelpful thoughts, yell "Stop!" to themselves, and come up with self-affirming thoughts.

SESSION 18: Visiting a Person with AIDS

To reduce teens' stereotypes about people with AIDS, and reinforce the point that HIV is not transmitted in everyday social encounters, this session enables students to meet and talk with HIV+ individuals. The facilitators encourage participants to ask questions, show respect and share their own feelings. Typically, the visit includes an informal meal. The visit is followed by a debriefing session in which group members can discuss their feelings and reactions to the meeting.

SESSION 19: Should I Be Tested for HIV?

The HIV Antibody Test Sheet is used to engage participants in a discussion of the test and the meaning of the results, whether positive or negative. Working in pairs, the teens explore their own possible reactions to a positive test result. Then group members raise and explore the question of whether they should be tested. In the field study of the program, the facilitators gave group members a list of local agencies, first where they could get tested and second, where they could receive treatment. You should prepare a comparable guide of resources in your own community.

SESSION 20: Using Self-Talk to Practice Safer Sex

The group leaders promote the idea that teens can feel better about themselves by giving themselves compliments and rewards. An exercise encourages group members to practice using self-talk, or talking to themselves, in tough situations. Finally, the group splits up by sex to participate in an activity that involves rewriting negative self-talk in a rap song.

SESSION 21: How to Choose Safe Friends

This session is designed to help participants assess the risks posed by their friends and sexual partners. In an introductory exercise, the teens learn that they often do not know which friends are HIV-positive. This exercise highlights two points: first, that you cannot tell if someone is HIV positive just by looking at them, and second, it is not who the person is, but what they do, that leads to HIV infection. For these reasons, the leaders emphasize, safe sex is essential. In a second exercise boys and girls meet separately to create lists of the qualities they like in partners. Strategies for starting and ending relationships are also explored, and the group practices screening partners through discussion and role playing.

SESSION 22: Looking over a Community Resource

The goal of this session is to introduce group members to community case management agencies that provide services to gay, lesbian and bisexual youth. A list of other local resources should also be given to participants.

SESSION 23: Dealing with Stigma

This session is designed to improve teens' skill in coping with social stigma, harassment, and violence. In the first part of the lesson, the leaders discuss ways in which various groups are stigmatized. Role-play exercises help the teens think about what they can do when harassed.

A PERSONAL COUNSELING SESSION

In addition to the group discussion sessions, each teen has an individual counseling session with a trained professional. The counselor first determines whether the adolescent is sexually active and then designs a plan to overcome barriers to practicing safer sex or maintaining abstinence. The counselor also addresses any questions the teen has regarding sex and HIV/AIDS.

SESSION 24: Making a Soap Opera on HIV/AIDS

To integrate the lessons of the previous sessions, the group creates an original soap opera on HIV/AIDS. The leaders first encourage the group to devise a story and choose script writers, a director, camera men or women, actors and editors. Once the story is complete, the skit is performed, videotaped and viewed.

SESSION 25: The End And the Beginning

During the final session, group members are asked to share their feelings about the program. Members explore their hopes for the future by creating postcards that they would mail to their peers in five years. A relaxation technique is used to help group members feel good as they offer their good-byes.

Program Materials: Replicating or Adapting *Adolescent Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens*

The following materials are needed to implement the *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens* program. All items are included in the PASHA program package.

Curriculum Materials

The *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens Curriculum Manual* describes the rationale and methods for the program. Step-by-step instructions for facilitating each session are included, along with tips and guidelines for implementation.

Adolescents Living Safely Activity Packets contain the activity cards and handout masters for 20 of the 25 program sessions (the remaining five sessions do not require packets). The cards and handouts are clearly labeled with the session number and the name of the activity or handout.

Additional Materials

The PASHA program package provides all of the curriculum materials needed to implement *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens* in your community. However, additional equipment is required to lead some of the sessions, including a video camera, TV and VCR, photocopier, chalkboard or flip chart and markers, pencils, index cards and small tokens cut from construction paper. You will also need supplies for the condom skills demonstration and training session, such as condoms and dental dams, lubricant and penis models, (e.g., cucumbers or bananas). These items can be obtained at a local grocery, pharmacy or drug store. Finally, you will need to prepare a resource guide of agencies providing STD/HIV/AIDS testing and treatment services in your local community.

How to Implement the Program

Lesson Preparation

Prior to the first lesson, staff members should read the entire *Adolescents Living Safely Curriculum Manual* thoroughly and view the program videotape. The manual contains a series of tips and guidelines for implementing the program, handling difficult sessions that arise during discussions, and working with at-risk youth. For example, the following tips are suggested for creating productive group sessions.

(1) Reward thoroughly any observable positive behavior.

(2) Be supportive.

(3) Give compliments.

(4) Be non-judgmental.

(5) Create a happy group.

(6) Encourage group cohesion.

(7) Model appropriate assertive behavior.

(8) Be firm.

(9) Illustrate points through modeling.

(10) Share personal experiences (not current hang-ups).

(11) Keep language simple.

(12) Encourage group members to share their own experiences.

(13) Build on strengths.

(14) Listen.

(15) Let the group members do the reacting, responding, thinking and analyzing.

(16) Be flexible.

(17) Keep trying. If one approach doesn't work, try another one.

Special Materials

In each session a Feeling Thermometer and small colored tokens are used with participants. The thermometer helps teens recognize, measure and appropriately express their feelings in a group setting. At various points during the discussion leaders will ask for volunteers to "take their temperature." At the low end of the scale is 0, indicating that one feels very, very comfortable. A measure of 100 represents the other extreme, a high level of discomfort. A Feeling Thermometer Master can be found in the Activity Packet for Session 1.

The colored tokens serve as symbols of one's appreciation for the contributions offered by a peer. The tokens are 2" square pieces of colored construction paper; a stack of these is given to each group member at the start of every session. When a participant does or says something that another person likes, agrees with, finds encouraging or causes him/her to think, the listener hands over a token and explains the reason for doing so.

In addition, you will need to develop a resource guide listing agencies providing STD/HIV/AIDS testing and treatment services in your local community. The list will be given to participants during Session 19.

Use of Two Co-Leaders

It is recommended that two leaders, one male and one female, co-facilitate each session. At the beginning of the program, the co-leaders establish control by directing activities, setting the pace and insuring that participants maintain self-control. One leader should direct the activities while the other monitors the process, giving feedback and helping the group stay focused. These responsibilities can be rotated regularly. When the full group divides into male and female teams, same-sex leaders facilitate.

Having leaders briefly review lesson outlines, role-play scripts, and checklists of activities and materials (in the *Adolescents Living Safely Curriculum Manual*) before the start of each session will ensure that meetings flow smoothly

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens* program was investigated in a field study conducted between 1988 and 1991 in New York City. The researchers recruited 138 male youths, ages 14 to 19, who sought services at the Hetrick-Martin Institute, a community-based agency providing recreational and social services to gay youths.

At the time of the study, there was only one site serving New York City's gay and bisexual youths, and the researchers feared that a comparison group selected from the same site would threaten validity. Moreover, given the scarcity of services for gay and bisexual youths, the researchers felt that it would be unethical to withhold the program and its related services from a group of teens. For these reasons, no comparison group was used.

The study focused on measures of high-risk sex acts, including the frequency of intercourse, number of partners and number of unprotected acts of oral and anal intercourse. To assess these behaviors, interviews were conducted with the gay males at four points;

- Time 1: Before the start of the study (baseline);
- Time 2: Three months following the baseline assessment (post-test);
- Time 3: Six months following the baseline assessment (six-month follow-up); and
- Time 4: Twelve months following the baseline assessment (twelve-month follow-up).

Data Collection Procedures

Following their regular intake interview for the institute, the youths were invited to participate in the field study. They were asked to complete an informed consent form and the baseline assessment interview. Participants received $2 for taking part in the baseline interview, and $20 to $25 for each of the follow-up assessments.

All interviews were conducted by three highly-skilled master's-level research assistants, under the supervision of a master's-level research psychologist. Of the original group of participants, 88% took part in at least one follow-up assessment, 79% completed two assessments and 52% completed all four assessments.

Sample

Among the 138 males originally recruited for the study, 51% were Hispanic, 31% were African-American, 12% were White and the remaining 6% were classified as "other." Sixty-six percent labeled themselves as gay, 25% bisexual, 3% straight, and 6% refused to identify with any of these labels.

Evaluation Questions

The researchers investigated whether program participation was associated with:

- a reduction in the number of unprotected active and receptive anal acts;
- a reduction in the number of unprotected active and receptive oral acts;
- abstinence from anal sex; and
- a reduction in the total number of sexual partners.

Evaluation Results

At the baseline assessment, most of the participating gay and bisexual males (89%) had engaged in sex in the course of their lives, and 70% said they had been sexually active during the previous three months. On measures of high-risk sex acts, about half (53%) had engaged in anal sex during the previous three months, and 60% of these youth had used a condom. Similarly, 61% of the teens had participated in oral sex during the previous three months, but only 28% had used a condom for protection. In addition, sexually active youth reported a median of 2.0 partners, and 7% of the sample had engaged in commercial sex. The researchers found no differences in the behaviors as a function of racial or ethnic background or age.

Following the program, the researchers measured significant reductions in a number of high-risk sex acts among participants. They also examined outcomes across racial and ethnic groups, as well as by involvement in commercial sexual activity, as explained below.

Anal Sex Acts

At the three-month follow-up assessment, program participation was associated with a decrease in unprotected anal sex for all but the Hispanic youths. At six months, the researchers found a positive association between the number of sessions attended and a reduction in risk acts, for White teens only. In contrast, both African-American and Hispanic teens showed an increase in unprotected anal sex acts at the six-month assessment. At the twelve-month follow-up, no significant outcomes were observed for any ethnic group.

Oral Sex Acts

There was a significant rise in the number of protected oral sex acts over the course of the field study. In particular, the mean proportion of protected oral sex acts rose from 28% at baseline to 45% at 12 months. At 12 months, among White and Hispanic teens, the frequency of risk activity decreased as the number of intervention sessions increased (when previous risk activity and commercial sexual activity were controlled). African-Americans significantly reduced their risk acts at three and six months, but not at the twelve-month follow-up.

Abstinence

Attending the *Adolescents Living Safely* program was not associated with significant increases in abstinence from anal sex.

Sexual Partners

Program participants significantly reduced the number of sexual partners following the intervention. In the three months prior to the baseline interview, the youths had an average of 2.2 partners. At the follow-up assessments, the average number of partners in the previous three months decreased to about 1.5 (three months=1.3, $p<.01$; six months=1.6, $p<.05$; twelve months=1.6, $p<.01$).This reduction was maintained through the twelve-month follow-up. However, the researchers found that program participation was not associated with any significant changes in the number of partners for oral or anal sex acts.

Ethnicity

Focusing on patterns of sexual activity across racial/ethnic groups, the researchers found that African-American teens showed significant and substantial reductions in both anal and oral risk acts over the study period. The proportion of protected anal acts rose from 36% at baseline to 80% at three months, 67% at six months and 84% at twelve months. Hispanic youths had somewhat higher percentages of protected sex at baseline (anal, 67%; oral, 31%) and these increased through six months (anal, 88%; oral, 31%). At one year, levels of protection returned toward baseline levels (anal, 72%; oral, 40%). Whites, Asian and Native American participants also showed positive shifts in their HIV risk acts, but the numbers were too small for significance testing.

Commercial Sexual Activity

The researchers found that gay and bisexual teens who engaged in commercial sexual activity increased their anal and oral sex risk acts over time, despite participation in the program.

Summary

The *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens* program, combining group discussions, behavioral skill development, peer support, personal counseling and case management, was associated with a number of positive changes in the sexual risk behaviors of teenage gay and bisexual males. In particular, the researchers measured a reduction in the number of unprotected acts of oral and anal sex, as well as a reduction in the number of sexual partners, among participating teens.

Overall, the researchers observed more positive outcomes for teens who had engaged in fewer risky acts prior to the study. In contrast, teens who had participated in commercial sexual activity showed an increase in the number of high-risk sex acts following the program. The findings also varied by ethnicity, with African-Americans showing the most dramatic reductions in unprotected anal and oral sex over the one year follow-up period.

In interpreting their results, the evaluators noted that the best predictor of future sexual behavior appears to be past behavior, and thus urged early intervention for HIV prevention. They also cautioned that without a comparison group, it is impossible to attribute positive changes to the effects of the program. Finally, because there were no measures of the dosage of specific components, the researchers could not determine which components hold the most promise for adolescent for risk reduction.

Evaluation Materials for *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments*, the *Prevention Minimum Evaluation Data Set (PMEDS)* and the *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

The instruments used in evaluating the field study of *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian and Bisexual Teens* are included in three *Original Evaluation Instruments* packets.

The *Baseline Interview* includes a comprehensive assessment of the teen's sexual history and patterns of sexual behavior in the previous three months. Three sections of the instruments should also be used for the follow-up assessment. Please note that many items are quite explicit—you may want to examine their suitability for use with your teens.

The *Tracking Information* interview gathers background data about your teens. This instrument only needs to be administered at the start of your study.

The *Values & Attitudes Survey* probes teens' feelings about sexuality and STD/HIV/AIDS-related preventive behaviors, as well as their perceptions of peer norms regarding sexual involvement. A second set of questions asks about recent life events the respondent may have experienced, such as moving to a new home or having a family member die. Finally, there are questions probing teens' psychological adjustment and knowledge about HIV transmission and prevention. In the original field study, this instrument was used at the Time 2, Time 3 and Time 4 assessments.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and

STD/HIV/AIDS prevention programs, including *Adolescents Living Safely: AIDS Awareness, Attitudes and Actions for Gay, Lesbian & Bisexual Teens*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations and phone numbers for experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

13

AIDS Prevention and Health Promotion among Women

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Bibliography

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Program Abstract

Title

AIDS Prevention and Health Promotion among Women

Summary

AIDS Prevention and Health Promotion among Women is designed to assist participants in developing and following a sound sexual health plan. Based on the concepts of empowerment, group social support, and culturally sensitive skill building, this program comprises four 1 1/2- to 2-hour small (2-8 participant) group sessions conducted over the course of three months. Video segments promote group discussion, spark group role plays and engage participants in cognitive rehearsal and guided fantasy exercises designed to encourage healthy choices about one's body and sexuality. Specifically, this program encourages women to think about the physical and emotional consequences of unsafe sex. It helps them achieve a sense of mastery and positive expectations when discussing sexual history, HIV/AIDS testing, monogamy, spermicide and condom use, and other health-related concerns with their partners. In addition, the program teaches participants how to effectively negotiate safer sex with one's partner and maintain safer-sex goals. This program was field tested with pregnant, low income African-American and white women who were using medical center obstetrics services in Akron, Ohio. Compared to control groups, participants showed significant and sustained increases in HIV/AIDS knowledge, safer-sex goals, and safer-sex behaviors, including spermicide and condom purchase and use.

Focus	☐ Primary pregnancy prevention	☐ Secondary pregnancy prevention	☑ STD/HIV/AIDS prevention
Original Site	☐ School-based	☐ Community-based	☑ Clinic-based

Suitable for Use In

AIDS Prevention and Health Promotion among Women can be implemented in clinics and community-based organizations. Although the original field study was conducted with pregnant women, the program is also appropriate for older adolescents and young adult women (ages 16+). In addition, because the program contains explicit information regarding IV drug use, it may be most suitable for groups engaging in high-risk behaviors.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☑ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☑ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age	The field test participants included 206 unmarried women in their second trimester of pregnancy who were using obstetric clinic services. Their ages ranged from 16 to 29 years; the average age of participants was 21.
Race/ Ethnicity	The field test population was 57% African-American, 40% white, 3% other ethnic origins.

Program Components

☐ Adult Involvement
☐ Case Management
☑ Group Discussion
☐ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☑ Role Play
☑ Video
☑ Other Guided imagery, group social support, cognitive rehearsal

Program Length

This program is designed to last a total of 6-8 hours. The program schedule is fairly flexible and can be adjusted to suit the particular site. However, it is recommended that the four program sessions be conducted over a period of two to three months, with participants attending a single 1 1/2- to 2-hour session every two or three weeks.

Staffing Requirements Training

A female masters-level psychologist or health educator should deliver the interventions. One facilitator is recommended for each group of up to eight women. The facilitator should have the ability to empathize with participants, a good working knowledge of AIDS and health concerns, and the ability to communicate a positive health message. Training should include group process skills, role playing and associated skills, and multicultural psychology. Video feedback on a practice session, if possible, is also suggested.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

AIDS Prevention and Health Promotion among Women is intended to help women incorporate safer-sex practices into their lives. This two- to three-month program uses four small group discussion sessions to engage women's thoughts and feelings concerning the consequences of unsafe sex. Guided fantasies are used to motivate women to adopt and maintain safer-sex practices. In addition, role play and cognitive rehearsal exercises help participants achieve a sense of mastery and positive expectations when discussing sexual history, HIV/AIDS testing, monogamy, spermicide and condom use, and other health related concerns with their partners. This program also directly addresses the relationship between drug and alcohol use and the risk of HIV infection. Specific instruction is given for cleaning drug works. Increased knowledge, confidence and skills provide a basis for participants to effectively negotiate safer sex with their partners. Furthermore, the group format provides support in setting and keeping safer-sex goals.

This program was developed by researchers from Kent State University, the Akron City Hospital and John Carroll University, with a grant from the National Institute of Mental Health and support from the Kent State University Applied Psychology Center. The program was initially field tested with a group of pregnant adolescents and women in Akron, Ohio between 1990 and 1993.

Theoretical Framework

The program is rooted in ideas of participant empowerment, socially sensitive skill building, and research indicating that a successful HIV/AIDS prevention program should:

(a) provide accurate information on transmission and safer-sex options, particularly condom use;

(b) raise participants' sense of their personal risk of infection;

(c) increase participants' belief that they can successfully perform safer-sex behaviors;

(d) increase social support for safer-sex behaviors; and

(e) increase participants' social and cultural acceptance of safer-sex behaviors.

The program is based on Bandura's Social Learning Theory (SLT) and Hobfoll's Conservation of Resources (COR) Theory.

SLT elaborates the processes through which intentions can be translated into behavioral change, and postulates that learning occurs through practice and observation of social models. Learning is mediated by internal beliefs about one's ability to succeed, as well as others' evaluation of one's own performance.

According to the theory, the likelihood of engaging in some action, such as using birth control, is determined by four factors:

(1) a person's understanding of what must be done to avoid pregnancy;

(2) the belief that one will be able to use the method;

(3) the belief that the method will be successful at preventing pregnancy; and

(4) the benefit one anticipates from accomplishing the behavior (e.g., preventing pregnancy through effective contraception).

Another important tenet of Social Learning Theory is that people learn skills by observing others' behavior and then imitating them. In *AIDS Prevention and Health Promotion among Women,* teachers and peers first model socially desirable behaviors, such as using birth control; then participants practice those behaviors in role plays.

COR Theory suggests that the threat of AIDS is an additional stressor facing women who are already overtaxed in their coping efforts. In such situations, COR Theory posits that an intervention must increase both the personal and social resources of women. COR Theory further suggests that target groups must see the intervention as both adding new resources and building on their current resource strengths.

Program Objectives

The overall goal of the program is to empower women to develop and employ a sound sexual health plan. Specifically, women will:

(1) know what behaviors put them at risk of exposure to HIV;

(2) understand methods for preventing exposure;

(3) achieve a sense of mastery and positive expectations when discussing sexual history, HIV/AIDS testing, monogamy, spermicide and condom use, and other health-related concerns with their partners; and

(4) develop safer-sex plans and practices.

Hypothesized Outcomes

It is hypothesized that program participants will increase:

(1) their knowledge about AIDS;

(2) their intention to adopt safer-sex practices, specifically spermicide and condom use; and

(3) their actual practice of safer sex.

Program Schedule

AIDS Prevention and Health Promotion among Women is composed of four 1 1/2- to 2-hour small-group sessions. Each session has several content themes incorporating role plays, cognitive rehearsal, guided fantasy and short video tape segments containing information and examples. During the original field study, the program developers identified four elements critical to the translation of program material into behavioral change. To be successful, the developers reasoned, the program should:

(1) integrate real and important issues from the participants' lives into the discussions;

(2) use the group format to encourage cohesiveness and support among participants;

(3) engage group facilitators (as opposed to group leaders) to promote mutuality and equality; and

(4) promote ongoing and authentic relationships among the participants and staff members.

These four elements should serve as goals in each program session.

The content of each individual session is summarized below. A more thorough description of the video tape segments and strategies for group facilitators appears in the *Program Manual*.

Session 1: **Drug Use, Alcohol Use and AIDS**

During this session, participants gain a sense of comfort in the group setting and discuss general health concerns, including drug and alcohol use and AIDS. They are also introduced to role play, cognitive rehearsal and guided fantasy exercises. This session uses the five video segments on the *Session 1: Drug Use, Alcohol Use and AIDS* tape.

Session 2: **Condom & Spermicide Use and Controlling the Conditions of Sexual Encounters**

During this session, participants learn the importance of using condoms and spermicide. They learn appropriate condom use and have the opportunity to practice this skill with a penis model. Following this exercise, they discuss potential barriers to safer-sex practices. Role play and cognitive rehearsal exercises are used to help participants gain a sense of confidence and positive expectations when purchasing condoms and spermicide, and in discussing their use with sexual partners. A guided fantasy exercise helps participants understand the emotional consequences of safer and nonsafer-sex plans. This session uses the five video segments on the *Session 2: Condom & Spermicide Use and Controlling the Conditions of Sexual Encounters* tape.

Session 3: **Sexual History, Saying No to an Unwanted Intensive Sexual Proposition, and Developing a Mutual Sexual Behavior Plan**

This session provides participants with information about communicating safer-sex behaviors with their partners, as well as opportunities to practice these skills. It covers issues such as discussing one's sexual history, AIDS testing, and developing a mutual safer-sex plan. Role plays and cognitive rehearsal are used to practice discussing these topics with partners, and to help participants discover potential barriers in these discussions. A guided fantasy exercise helps participants realize the physical and emotional outcomes from following/not following a safer-sex plan. This session uses the five video segments on the *Session 3: Sexual History, Saying No to an Unwanted Intensive Sexual Proposition, and Developing a Mutual Sexual Behavior Plan* tape.

Session 4: **Relapse Prevention, Post-Intervention Sexual Life, Alternatives to Intercourse, Mutual Monogamy, and Cleaning Drug Works**

In the final session women discuss their post-intervention sexual options and strategies for maintaining their safer-sex plans after the program. In addition, they receive information on how to clean IV drug works. Role plays and cognitive rehearsals help participants gain a sense of mastery and positive expectations when discussing the maintenance of their safer-sex plan with their partners. A guided fantasy exercise helps them realize the consequences of maintaining/not maintaining their safer-sex action plan. This session uses the five segments on the video tape *Session 4: Relapse Prevention, Post-Intervention Sexual Life, Alternatives to Intercourse, Mutual Monogamy, and Cleaning Drug Works.*

Program Materials: Replicating or Adapting *AIDS Prevention and Health Promotion among Women*

The *AIDS Prevention and Health Promotion among Women* program can be obtained from the Program Archive on Sexuality, Health & Adolescence. See the Order Form at the back of the book. The following materials, which are all included in your PASHA program package, are needed to implement the *AIDS Prevention and Health Promotion among Women* program. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Program Manual

AIDS Prevention and Health Promotion among Women Program Manual (Program Manual). The *Program Manual* should help the group facilitator conduct the four program sessions. The manual contains detailed instructions for each session, including discussion questions, role play and guided imagery scenarios.

Four Session Videotapes

Session 1: Drug Use, Alcohol Use and AIDS videotape. This video provides general health information and information about AIDS. It also introduces participants to role play, cognitive rehearsal and guided fantasy exercises.

Session 2: Condom and Spermicide Use and Controlling the Conditions of Sexual Encounters videotape. This video provides information on condom and spermicide use, including a demonstration on correctly using a condom, as well as role plays involving condom purchases and negotiating condom use. A cognitive rehearsal exercise is provided to help participants imagine possible barriers to correctly using condoms. A guided fantasy exercise is included to help participants realize the differing outcomes obtained when using, and not using, condoms and spermicide.

Session 3: Sexual History, Saying No to an Unwanted Intensive Sexual Proposition, and Developing a Mutual Sexual Behavior Plan videotape. This video provides information on the importance of discussing one's sexual history and ways to negotiate safer-sex plans with a partner. It contains a role play demonstrating techniques for discussing one's sexual history with a partner, as well as cognitive rehearsal and guided fantasy exercises.

Session 4: Relapse Prevention, Post-Intervention Sexual Life, Alternatives to Intercourse, Mutual Monogamy, and Cleaning Drug Works videotape. This video includes information on options for safer sex, planning to prevent relapses into unsafe sex practices, and techniques for cleaning IV drug works. Role play, cognitive rehearsal and guided fantasy exercises reinforce the session content.

Additional Materials

The PASHA program package contains everything you will need to implement the program, except for the following: a TV and VCR (which should be available at your clinic or community center), condoms, and penis models. In the field test, participants were given credit cards with which to purchase condoms and spermicide confidentially. Gift certificates or coupons (with an ID number but no name) could be substituted for this purpose.

How to Implement the Program

AIDS Prevention and Health Promotion among Women requires specially trained, female master's level psychologists or health educators to facilitate the sessions. There should be one facilitator for each group of up to eight women. The facilitators should be chosen for their ability to empathize with participants, as well as their working knowledge of AIDS and health concerns, and the ability to communicate a positive health message.

Training for the facilitators should include:

(1) group process skills for facilitating interactive discussions;

(2) practice in role playing and role play skills to help participants gain mastery of sexual communication and negotiation;

(3) cognitive rehearsal skills to help participants develop safer-sex plans;

(4) multicultural psychology and sensitivity to racial and cultural diversity; and

(5) videotaped feedback, if possible, so that facilitators will have a chance to evaluate and adjust their own skills.

Facilitators should also be completely familiar with the video exercises that form the core of this program. It is recommended that they watch them, read through the *Program Manual*, and practice, with each other or with another group of women, each of the video exercises. Because the needs and interests of each group of women will differ, pre-developed discussion, role-play and cognitive rehearsal scripts tend to be overly limiting and are not particularly helpful. Practice in group interaction and role playing should give trained facilitators the ability to integrate the life experiences and concerns of participants into the program.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of *AIDS Prevention and Health Promotion among Women* was originally assessed in a field study in Akron, Ohio. The study compared the HIV/AIDS knowledge, safer-sex plans and safer-sex practices of three groups of women. One group received the intervention described in the program materials above (*AIDS Prevention group*). A second group participated in a comparable health program (*General Health Promotion group*) in which they were taught identical skills (i.e. negotiation in sexual situations, making a general sexual health plan), using identical methods (information, role play, cognitive rehearsal and guided fantasy exercises) in the same amount of time, but which did not include AIDS-specific information. A third group, who received no intervention, was used as a control (*Control group*). Data were collected from all participants at three points:

Time 1: before the start of the program (pre-intervention);

Time 2: immediately following the end of the program (post-intervention); and

Time 3: six months after the end of the program (six-month follow-up).

The 206 original study participants were all single women, in their second trimester of pregnancy, who sought obstetrical care at one of three inner-city clinics for low-income women.

Evaluation Questions

Three questions guided the field study.

(1) What effect did the intervention have on participants' knowledge about AIDS?

(2) What effect did the intervention have on participants' intent to adopt safer-sex practices?

(3) What effect did the intervention have on participants' actual practice of safer sex?

Data Collection Procedures

Participants were recruited when they sought obstetrical services at one of three clinics serving low-income women in Akron, Ohio. Eighty percent of those asked agreed to participate in the study. Pre-intervention data were collected at the initial contact. Participants were paid $10 for completing the first survey, $15 for the post-intervention survey, and $20 for the follow-up. To help offset the cost of transportation and child care, women in both the *AIDS Prevention* and *General Health Promotion* groups also received $5 for each group session they attended.

At each assessment period, participants completed a questionnaire with the following measures.

- Safer-sex knowledge. This 13-item scale measures knowledge of AIDS transmission and prevention.
- Condom and spermicide usage. This 4-item scale measures condom and spermicide use during vaginal and anal sex in the few weeks preceding the study.
- Abstinence and number of partners. These items assess women's sexual behavior over the past year, including the number of partners.
- Discussion with partners. One item probes whether women discuss AIDS-related behavior with their partners.
- Intention to purchase, and purchase of condoms and spermicide. In this 4-item scale, women report on their intent to purchase condoms and/or spermicide in the future and whether they have recently obtained condoms and/or spermicide.

In addition to the self-report items, the evaluators measured the actual condom and spermicide purchases by participants. At the start of the study, participants received credit cards containing their photo and an ID number, but not their name. These credit cards could be used to purchase condoms and spermicide at pharmacies near their clinic. The evaluators obtained reports of the women's purchases from local pharmacies.

Original Intervention Sample

Study participants were single women in their second trimester of pregnancy, who had not lived with a partner steadily during the last six months. Women who were under treatment for a chronic illness, such as diabetes or kidney disorders, were excluded. Minors needed parental permission for their participation. Slightly more than half (57%) of the participants in this study were African-American and 40% were white; the remaining 3% were of other ethnic origins. Most of the participants (75%) had incomes under $10,000 per year.

For the two intervention groups, all participants who completed three or more sessions were included in the sample. Thirty-seven women began the study but did not complete it. The only difference between participants who were included and excluded from the study was that those who attended fewer than three sessions were slightly better educated.

Evaluation Results

Compared to their peers in the *General Health Promotion* and *Control* groups, members of the *AIDS Prevention* group showed the most favorable outcomes, particularly on measures of safer-sex intentions and practices. Although most of the changes were moderate in magnitude, they were maintained at the six month follow-up. The intervention was equally effective for African-American and white women. The *AIDS Prevention* participants showed the following outcomes.

(1) Increased AIDS knowledge. Participants in the *AIDS Prevention* group had significantly greater AIDS knowledge than the no-intervention controls on the 13-item safer-sex questionnaire.

(2) Increased discussion of AIDS with a partner. *AIDS Prevention* group members were significantly more likely than the no-intervention group to discuss AIDS-related behavior with a sexual partner.

(3) Safer-sex intentions and practices. The *AIDS Prevention* group showed greater increases in safer-sex intentions and practices than either the *General Health Promotion* or the *Control* groups.

(4) Increased reported usage of condoms and spermicide. Participants in the *AIDS Prevention* group reported a greater

increase in their use of condoms and spermicide compared to the no-intervention group.

(5) Increased acquisition of condoms and spermicide. Compared to their peers in the other two groups, *AIDS Prevention* participants showed the most significant gains in condom and spermicide acquisition.

(All of the results reported above were significant at the $p<.05$ level.)

Overall, the intervention showed no effect on abstinence or the number of sexual partners. The evaluators observed that because few of the participants had had more than five partners in the year preceding the study, significant change might be difficult to measure.

Summary

The results of this evaluation show that *AIDS Prevention and Health Promotion among Women* can produce significant changes in women's safer-sex behavior. The combination of AIDS-related information and skills practice was more effective in getting women to develop healthy sexual plans than the health-only intervention. Women in the *AIDS Prevention* group demonstrated significant, lasting change in their knowledge of AIDS prevention, communication about AIDS, intentions and actual behaviors concerning safer-sex behaviors, as well as condom and spermicide acquisition and use.

Evaluation Materials for *AIDS Prevention and Health Promotion among Women*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments,* the *Prevention Minimum Evaluation Data Set (PMEDS)* and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites with new groups of teens.

Original Evaluation Materials

The original questionnaire used for evaluating *AIDS Prevention and Health Promotion among Women* is contained in the *Original Evaluation Instruments*. This survey includes questions on family background, safer-sex values, attitudes, knowledge and behavior, and patterns of communication with sexual partner(s). There are several questions on specific sexual behaviors (e.g., fellatio, anal sex, mutual masturbation). These questions may or may not be appropriate for your target population and/or community.

Before using these or any evaluation instruments with your teens, it is very important that consent and approval be received from the appropriate people in your community (e.g., school officials, parents).

The same questionnaire is given at all three assessment periods:

Time 1: before the start of the program;
Time 2: immediately following the program; and
Time 3: six months following the completion of the program.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *AIDS Prevention and Health Promotion Among Women*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

14

AIDS Prevention for Adolescents in School

An Adolescent STD/HIV/AIDS Prevention Program

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Program Abstract

Title **AIDS Prevention for Adolescents in School**

Summary This six-session program for high school students is delivered by regular classroom teachers. Combining principles of the health belief model with social psychology, the curriculum aims to improve students' knowledge, beliefs, self-efficacy, and risk behaviors concerning HIV/AIDS. The first two classes provide general information about transmission and prevention of HIV/AIDS and teach students how to appraise their own risk behaviors. During the next two sessions, myths about peers' sexual behaviors are corrected, values clarification is introduced, and students use role play and negotiation skills to practice delaying sexual intercourse. The final lessons involve discussions of purchasing and using condoms, and students use role play and negotiation skills to practice consistent condom use.

A field study of the program was conducted with a predominantly African-American and Hispanic sample of students attending four New York City public high schools. At the three month follow-up assessment, compared with a comparison group of peers, program participants scored significantly better on measures of knowledge, beliefs about the benefits of risk reduction, beliefs about the commonness of risky and preventive behaviors among their peers and beliefs about one's own ability to effect positive change (e.g., self-efficacy). The program also was found to be effective in reducing sexually active participants' number of total sex partners and number of high-risk sex partners, and in increasing their use of condoms.

Focus ☐ Primary pregnancy prevention ☐ Secondary pregnancy prevention ☑ STD/HIV/AIDS prevention

Original Site ☑ School-based ☐ Community-based ☐ Clinic-based

Suitable for Use In

Although it was originally implemented in high school classrooms, this program is equally suitable for use in community-based organizations.

Approach

☑ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☐ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☑ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Study Sample

Age	The field study included 1,201 students ages 12 to 20 years (avg. age=15.7 yrs.).
Gender	58% Female
Race/ Ethnicity	37% African-American, 35% Hispanic, and 28% other (mostly non-Hispanic White or Asian).

Program Components

☐ Adult Involvement
☐ Case Management
☑ Group Discussion
☑ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☑ Role Play
☑ Video
☐ Other __________

Program Length

The six-hour program is divided into six class lessons that are delivered on consecutive school days.

Staffing Requirement/ Training

Regular classroom teachers implement the program. A one-day in-service training session is recommended to introduce teachers to the curriculum's objectives and activities.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form in provided at the back of this book for your convenience.

The Program

Program Rationale and History

AIDS Prevention for Adolescents in School is a six-session, school-based program aimed at reducing transmission of the HIV virus among teenagers. The curriculum is designed to increase students' knowledge about HIV/AIDS, modify their beliefs about the risks of infection, improve their motivation and ability to avoid risky situations, and ultimately, empower teens to reduce their sexual risk behavior.

The program was originally developed to meet the particular needs of multi-ethnic, inner-city teens. A team of health professionals with specialized training in preventive medicine, public health, adolescent psychiatry and adolescent medicine developed the curriculum, using the results of a needs assessment survey. The survey documented high levels of sexual risk behaviors among the target population of teens, including unprotected intercourse, intercourse with multiple partners, and intercourse with high-risk partners. Additionally, the program developers recognized that adolescents/young adults comprise one of the fastest growing groups of people with AIDS, and African-Americans and Hispanics are disproportionately represented among both urban AIDS cases and urban HIV-positive teens.

A field study of the program was conducted with 1,201 predominantly African-American and Hispanic high school students in New York City in 1990/91. The National Institute of Mental Health funded the *AIDS Prevention for Adolescents in School* program as part of a five-year research and service project led by Columbia University in collaboration with the New York City Board of Education and New York City High Schools.

Theoretical Framework

Two analytic perspectives, Social Cognitive Theory and the Health Belief Model, guided development of the program.

Principles of the Health Belief Model suggest that individuals will be likely to engage in health-related behaviors when the following conditions are met:

(1) one perceives that the problem (e.g., HIV/AIDS) poses a serious threat to one's well-being;

(2) one understands the benefits and barriers to taking preventive action; and

(3) one feels able to effectively carry out the recommended actions.

Similarly, Social Cognitive Theory is based on the idea that knowledge alone is insufficient to produce behavioral change. Instead, the theory points toward four factors that together determine the likelihood of engaging in some action, such as using condoms to protect oneself from HIV/AIDS: (1) a person's understanding of what must be done to avoid infection; (2) the belief that one will be able to use condoms; (3) the belief that the method will be successful in preventing infection; and (4) the benefit one anticipates from accomplishing the behavior (e.g., staying healthy).

The original program developers reasoned that adolescents are particularly at risk for HIV infection because they frequently possess relatively low levels of self-efficacy, or confidence in their ability to perform a particular behavior successfully, such as to negotiate the use of a condom with one's partner. The developers also identified personal skills as important factors in determining how (and how successfully) teens will act. For this reason, the *AIDS Prevention for Adolescents in School* curriculum aims to develop students' resistance and negotiation skills for acting in sexual situations, including correctly using a condom, saying "no," and removing oneself from unsafe situations.

Moreover, because Social Cognitive Theory links learning to repeated observation and imitation, the program instructor models socially desirable behaviors, and students practice these behaviors through role plays.

Program Objectives

The overall goal of the curriculum is to reduce transmission of HIV among teenagers. Additionally, the program is designed to meet the following objectives:

(1) to convey correct facts about HIV transmission and prevention to students;

(2) to teach students to accurately appraise their risk of getting HIV/AIDS, based on their own behaviors, and to foster an appropriate level of concern based on this appraisal;

(3) to direct students to appropriate AIDS-preventive resources within their school and local community;

(4) to help students clarify their personal values relating to involvement in sexual intercourse, and to facilitate an understanding of the effects of outside influences on these values;

(5) to empower students to develop the negotiation skills necessary to delay sexual intercourse; and

(6) to empower students to develop the negotiation skills necessary to acquire condoms and use them consistently and effectively.

Hypothesized Outcomes

It is hypothesized that participation in the *AIDS Prevention for Adolescents in School* program will be associated with:

- increased knowledge about HIV/AIDS;
- increased belief in the benefits of risk reduction;
- increased belief in one's ability to change one's own behaviors and reduce the risk of infection;
- fewer sex partners and high-risk partners; and
- increased use of condoms.

The original field study targeted multi-ethnic, inner-city teens—other groups of participants may show more dramatic results following the intervention.

Program Activities

The six-lesson curriculum aims to effect change in students' knowledge, beliefs, self-efficacy and sexual-risk behaviors through the following three activities.

(1) **Lectures**. A lecture format is used during the first session so that teachers or program leaders can convey important facts about HIV/AIDS to the class. The lecture can be informally structured and combined with group discussions.

(2) **Group Discussion**. Throughout the program discussions are used to address students' questions, explore new concerns, review program activities and out-of-class assignments, share personal values relating to sex, and evaluate role-playing scenarios and negotiation strategies.

(3) **Role play**. This powerful learning technique is used extensively during the final sessions to enhance the development of life skills, particularly those that will help teens resist pressures to engage in HIV-risk behaviors. Through role play, participants can experience real-life social pressures to engage in unsafe behaviors and react spontaneously to these pressures. Students can also assess their personal

reactions and develop the negotiation and assertiveness skills that are necessary to resist such pressures in their daily lives.

Program Schedule

Listed below are brief summaries of the six program lessons. During the field study of the program, the lessons were held on consecutive days and led by regular classroom teachers.

LESSON #1

This lesson is designed to increase students' basic understanding of HIV/AIDS, including transmission and prevention. In the field study of the program, a guest speaker was invited to deliver this lecture to the class. A few days prior to the start of the lesson, students should be asked to write down their questions about the disease. The guest speaker (or program instructor) can address these questions during his/her presentation.

LESSON #2

In this lesson students learn how to appraise their risk of acquiring HIV/AIDS with a Rate the Risk worksheets and a series of vignettes about teens. In addition, they are encouraged to stop engaging in any risky behaviors, to explore the reasons why they were involved in such activities, to practice preventive measures and to consider getting an HIV antibody test. During the second half of the class, the group reviews the AIDS Resource Guide. In the field study, this guide provided information about medical and social services for teens in New York City; using the guide as a template, you can prepare a similar handbook for your local community. For homework, students are asked to find an advertisement that appeals to them and determine whether and how it uses sexual imagery to promote the product.

LESSON #3

This lesson encourages students to clarify their personal values about engaging in sexual intercourse. It is also designed to help participants understand the ways in which outside influences (such as peer pressure and the media) can influence their values and beliefs about intercourse. In the original field study, posters were presented to compare the proportion of students who believed their peers had been sexually active with the proportion of students who actually were sexually active, and to compare the proportion of students who were sexually active with the proportion of students who believe they should be sexually active. The purpose of this exercise was to demonstrate that teens tend to overestimate their peers' involvement in sexual activity, and to underestimate the number of their peers who believe that students their age should not have sex. You could design such posters, or point out to the class that most high school students feel that they should not yet be sexually active. As a group, the class can discuss reasons why one might choose to delay sexual involvement, as well as poor reasons for having sex before one is ready. In the next activity, the class considers how the media and other influences can pressure teens into feeling that they should act in ways that conflict with their personal values. Students are invited to share the advertisements they analyzed for the Lesson #2 homework assignment.

LESSON #4

The purpose of this lesson is to empower students to develop and apply the negotiation skills necessary to delay involvement in sexual intercourse. The session begins with a group discussion and role play of "lines" that are used to persuade others to have sex. The group considers circumstances in which it can be difficult to say no. Additional role plays are used to help students practice responding to typical "lines" by saying no persuasively. One pair of students can act out the scenario in front of the class, while the rest of the group offers feedback.

LESSON #5

Helping students develop skills and confidence to use condoms are the goals of this session. At the start of the period, the class views the *Tracee and Andy Think It Through* video clip. The video shows a teenage girl who feels ready to begin having sex with her boyfriend. She would like her boyfriend to use condoms but is unsure how to approach him. Following the video, the class discusses ways that Tracee could convince Andy to use condoms. Additional role play activities provide students with opportunities to practice their condom negotiation skills. The class also considers other barriers they may face to using condoms, such as the belief that they are unnatural, or that they are unnecessary if neither partner is infected.

LESSON #6

The final lesson is designed to help students feel comfortable buying and using condoms. First the teacher demonstrates the correct way to put on and remove a condom, using a zucchini or banana as a penile model. Then the class discusses where and how to buy condoms. This information is summarized for students on the

Condom Fact Sheet that is included in the *AIDS Prevention for Adolescents in School Student Activity Booklet.*

Program Materials: Replicating or Adapting *AIDS Prevention for Adolescents in School*

The *AIDS Prevention for Adolescents in School* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence. See the Order Form at the back of the book. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package. The program includes the following materials needed to implement this program in your community or school:

AIDS Prevention for Adolescents in School Curriculum Handbook (also referred to as the *Curriculum Handbook*). The *Curriculum Handbook* is designed to guide teachers in implementing *AIDS Prevention for Adolescents in School* in their classes. It provides detailed lesson plans for the six class sessions, and describes the purpose and methods of the program, background information on HIV/AIDS, and tips for leading successful role play exercises. Master copies of all fact sheets and In- and Out-of-Class activity sheets are also included in the *Curriculum Handbook*.

Tracee and Andy Think It Through. In this brief, 4-minute video clip, a teenage girl considers how she should discuss the use of condoms with her boyfriend, now that she feels ready to begin having sex.

AIDS Prevention for Adolescents in School Student Activity Booklet Masters. This packet includes one copy of all program fact sheets and In-Class and Out-of-Class activity sheets.

Additional Materials

The PASHA program package provides everything needed to implement the *AIDS Prevention for Adolescents in School* program, except for the following materials, which should be available in your school or community: a TV and VCR; chalkboard or flip chart and markers; photocopier; condoms; spermicide foam; a model for demonstrating condom use (e.g., penile model, banana); and a cardboard box in which students can put their anonymous questions. In addition, a resource guide to local medical and social services for teens will need to be compiled for Lesson #2; the sample guide included in the *Curriculum Handbook* can assist you in developing one for your own community.

How to Implement the Program

During the original field study, a full-day training session was held prior to the start of the program. Designed to enhance instructors' fidelity to program materials, the training included a review of the curriculum, discussion of HIV/AIDS and youth, and practice facilitating the group exercises. You may organize a similar session for your staff. Alternatively, you may rely on the *Curriculum Handbook*, which provides a comprehensive overview to the program. Studying the handbook should provide ample preparation for instructors, particularly those who are comfortable and experienced in facilitating group activities and discussing sexuality with youth.

Before your program begins, you will need to decide whether a regular classroom teacher or a guest speaker will lead the discussion of HIV/AIDS that takes place during Lesson #1. If you choose to invite a guest speaker, you should do this ahead of time. You will also need to identify and locate medical and social services for teens in your local community. Use this information to prepare the resource guide that will be distributed to students during Lesson #2.

Finally, at the front of the *Curriculum Handbook* are several important resources that teachers will want to study before the program begins: an overview of program goals, a discussion of program evaluation, an introduction to the curriculum, tips for leading role-play exercises, and a brief discussion of HIV transmission, prevention, symptoms, and testing.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the *AIDS Prevention for Adolescents in School* program was investigated in a field study conducted in four public high schools that were demographically representative of the entire high school population in New York City. Ninth and eleventh grade students in two schools served as the intervention group (program participants), and ninth and eleventh grade students in two other schools served as the comparison group.

The study compared changes in the intervention and comparison group members' HIV/AIDS-related knowledge, beliefs, self-efficacy and sexual risk behaviors. To assess these changes, self-report questionnaires were administered to all students at two points:

- Time 1: about two weeks prior to the start of the intervention (Pre-Test); and
- Time 2: three months following the conclusion of the program (3-Month Follow-Up).

Evaluation Questions

The researchers examined the effect of participation in the *AIDS Prevention for Adolescents in School* program on several outcome measures. In particular, they considered whether, as predicted, program participants showed:

(1) increased HIV/AIDS-related knowledge;

(2) increased belief in the benefits of risk reduction;

(3) more accurate beliefs about the commonness and acceptability of risky and preventive behaviors among peers;

(4) improved self-efficacy; and

(5) reduced HIV/AIDS risk behavior.

Data Collection Procedures

A 94-item questionnaire was administered to students by research staff first, approximately two weeks before the program began, and again, about three months following the intervention. In addition, to provide a measure of the reliability of the instrument, 10% of the students were randomly selected to complete the survey one extra time, two weeks following the Time 1 assessment.

Because the student questionnaire was considered to be part of a customary educational evaluation, the New York City Board of Education waived its usual parental consent procedures. However, students were assured that their responses were voluntary and confidential, and would be reported only in the aggregate. To enable the researchers to track the youth for the duration of the study, individual surveys were identified by students' four-digit school identification numbers.

Sample

The full study sample comprised 667 program participants and 534 comparison students; more females than males (58% vs. 42%) participated. Youth ranged in age from 12 to 20; on average, students were nearly 16 years old. Within the sample, 37% of the teens were African-American, 35% were Hispanic, and 28% were "other."

Evaluation Results

At the Time 1 assessment, one-third of the sample reported engaging in sexual intercourse during the past three months. Of those who were sexually active, more than half said that they used condoms inconsistently or not at all, 20% reported having two or more sexual partners, and 5% reported having intercourse with high-risk (e.g., IV drug using) partners. Overall, more than two-thirds of the sexually active students showed some evidence of high-risk behaviors at the start of the study.

At the Time 1 assessment, program participants showed slightly higher behavior risk scores, as well as lower levels of HIV/AIDS-knowledge than their comparison group peers. At the follow-up assessment, program participants scored significantly higher than the comparison group on five of eight outcome measures, as explained below. In addition, none of the effects appeared to vary significantly by students' school, age, gender, race/ethnicity or by their classroom teacher. Furthermore, teachers' effectiveness in leading the program was found to be unrelated to the outcome measures.

HIV/AIDS-Related Knowledge

Following the *AIDS Prevention for Adolescents in School* program, participants showed significant gains in their HIV/AIDS-related knowledge. Their scores rose from 75.6 at baseline to 85.5 at the three-month follow-up assessment, as compared to 78.8 (baseline) and 81.2 (follow-up) for the comparison group students ($p<.0001$).

Beliefs about the Benefits of Risk Reduction

Program participation was associated with significant gains regarding beliefs about the benefits of risk reduction. Participants' scores rose from 3.5 at baseline to 3.8 at follow-up, compared to 3.7 (baseline) and 3.8 (follow-up) for the comparison group ($p<.0001$).

Beliefs about Peer Norms

Program participants showed significant gains in the accuracy of their beliefs about the commonness of peer risk and preventive behaviors. For participants, scores rose from 2.8 to 2.9 following the intervention, while the comparison group's scores remained level at 2.8 (p<.003).

Self-Efficacy

Program participants' belief in their ability to successfully perform AIDS-preventive actions rose from 3.7 to 3.9 between the Time 1 and Time 2 assessments. This change was significantly higher than that observed for the comparison group, whose scores rose from 3.7 to 3.8 (p<.03).

Sexual Risk Behavior

Program participants showed a significant reduction in an index of sexual risk behavior, with scores declining from 1.5 to 1.3 between the Time 1 and Time 2 assessments. The risk score for the comparison group increased from 1.0 to 1.3 during the same time period (p<.006).

In a breakdown of this index, the program was found to be most effective at increasing sexual monogamy and condom use, and in reducing the number of total sex partners and high-risk sex partners. The intervention showed no effect on sexual abstinence.

On the three remaining outcome measures— beliefs about one's susceptibility to HIV/AIDS, beliefs about barriers to using protection, and beliefs about the acceptability of risky and preventive behaviors—no significant differences were found between the two groups of students.

Summary

The three-month follow-up data provide evidence that the *AIDS Prevention for Adolescents in School* program had a statistically significant effect in reducing teenagers' sexual risk behaviors. Students who participated in the program also showed favorable changes in their knowledge, beliefs and self-efficacy related to AIDS-preventive actions. It is noteworthy that these effects were found across a broad spectrum of inner city, largely minority adolescent students, participating in a brief (six-hour) intervention.

In interpreting the results, the researchers offered two caveats. First, they noted that their sample of teens included students sufficiently motivated to attend school. In contrast, such positive outcomes might not be found with teenagers who are habitually absent or who have dropped out of school, or with teens who show riskier sexual behavior profiles. In fact, the program may have limited effectiveness for such youths, who are at the highest risk of acquiring HIV infection.

In addition, the researchers noted that the program was of very limited duration. To produce dramatic behavioral change, it is important to supplement short-term educational interventions with intensive, broad-based prevention activities.

Evaluation Materials for *AIDS Prevention for Adolescents in School*

In addition to the program materials described in an earlier section, the PASHA program package includes two resources for evaluation: the *Prevention Minimum Evaluation Data Set (PMEDS)* and the *Local Evaluator Consultant Network Directory*. These materials are designed to help you begin evaluating your program, should you choose to do so.

PMEDS

The evaluation instruments used by the original program evaluator are no longer available. In their place, your PASHA program package includes a generic instrument that can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs including *AIDS Prevention for Adolescents in School*. Designed for self-administration with teens between 13 and 19 years of age, this instrument incorporates standardized measures of participants' knowledge, behaviors, and attitudes.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants for teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

15

ARREST: AIDS Risk Reduction Education and Skills Training Program

Original Program Developers and Evaluators	Michele D. Kipke, Ph.D. Division of Adolescent Medicine Childrens Hospital Los Angeles Los Angeles, CA
Program Guide Prepared by	Anne Belden, M.A. Starr Niego, Ph.D.
Bibliography	Kipke, M. D., Boyer, C., & Hein, K. (1993). An evaluation of an AIDS risk reduction education and skills training (ARREST) program. *Journal of Adolescent Health*, 14(7), 533-539.

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Program Abstract

Title

ARREST: AIDS Risk Reduction Education and Skills Training Program

Summary

Principles of the health belief model and social learning theory form the framework for this program, together with strategies previously found to be effective in changing such adolescent health-risk behaviors as cigarette smoking and early pregnancy. Originally targeted toward high-risk teens between 12 and 16 years of age, the curriculum spans three 90-minute, small group sessions. Participants receive: (1) information about transmission and prevention of HIV/AIDS; (2) instruction and demonstration of purchasing and using condoms with spermicide; (3) guidance in self-assessment of risk behaviors; (4) training in decision-making, communication, and assertiveness skills; and (5) peer group support for HIV/AIDS prevention and risk reduction. The teens complete role plays, skill-building exercises and homework activities. For the duration of the program, they are also asked to record their HIV/AIDS-related thoughts, feelings, and behaviors in a confidential log book.

A field study of the program was conducted with 87 African-American and Latino youths, who were recruited from three New York City community-based organizations providing alternative education and after-school programs for high-risk teens. Comparing four week follow-up measures of program participants with a control group of peers, participants showed significant gains in knowledge and attitudes about AIDS, as well as in sexual refusal and negotiation skills. However, no differences were found between the groups' risk-related sexual behaviors.

Focus	☐ Primary pregnancy prevention	☐ Secondary pregnancy prevention	☑ STD/HIV/AIDS prevention
Original Site	☐ School-based	☑ Community-based	☐ Clinic-based

Suitable for Use In

Although it was originally implemented in a community-based organization, this program is equally suitable for use in schools.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☐ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☐ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age	The field study included 87 at-risk participants, ages 12 to 16 years (avg.=13.8).
Gender	55% Female
Race/ Ethnicity	59% Latino, 41% African-American

Program Components

☐ Adult Involvement
☐ Case Management
☑ Group Discussion
☑ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☑ Role Play
☐ Video
☑ Other peer support groups

Program Length

The 4 1/2 hour program is divided into three 90-minute training sessions.

Staffing Requirements /Training

One skilled HIV/AIDS educator is recommended to lead each group of 10 to 12 students.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

Designed for use with high-risk adolescents ages 12 to 16, the *AIDS Risk Reduction Education and Skills Training Program (ARREST)* aims to (1) provide teens with information and instruction on HIV/AIDS; (2) enhance their ability to assess the risk level of their own behavior; and (3) foster the decision-making, assertiveness and communication skills that are required for effective prevention and risk reduction. The three-session program was originally targeted toward African-American and Latino youth, who may be especially vulnerable to HIV infection. Survey data suggest that these groups of teens begin having sex at earlier ages, and they show higher rates of unplanned pregnancies and sexually transmitted diseases. Yet, the curriculum is equally suitable for use with adolescents of all races and ethnicities.

Despite reports that teenagers are well-informed about HIV transmission and prevention, the program developers found that most do not think they are at risk of becoming infected. Moreover, many younger adolescents have not developed the kinds of skills that are needed for HIV prevention and risk reduction. Typically, for example, these teens are not well prepared to negotiate with sexual partners or resist peer pressure in situations where HIV infection is a risk. They are also likely to lack the confidence and skills required to purchase and properly use condoms. To address these issues, the *ARREST* curriculum provides explicit instruction, role modeling and repeated practice in purchasing and putting on condoms, negotiating safer sex with one's partner and removing oneself from risky situations involving alcohol, drugs and unprotected sex.

A field study of the program was conducted in 1989 in New York City. The researchers recruited 87 African-American and Latino teens from three community-based agencies serving high-risk youth. Funding for the study was provided in part by the Carnegie Corporation, Health Resources and Service Administration, The Rockefeller Brothers Fund, the Fund for the City of New York, Morgan Guaranty Trust Company, W.T. Grant Foundation, Design Industries Foundation for AIDS and The Samuel and Mary Rudin Foundation.

Theoretical Framework

The *AIDS Risk Reduction Education and Skills Training Program* integrates two theories for promoting healthy behavior in youth: the Health Belief Model and Social Learning Theory.

These theories are premised on the idea that knowledge alone is insufficient to produce behavioral change. Instead, they suggest that individuals are likely to reduce their HIV risk-related behaviors when the following conditions are met:

(1) one perceives that the problem (e.g., HIV/AIDS) poses a threat to one's well-being;

(2) one understands what must be done to avoid infection;

(3) one understands the benefits and barriers to taking preventive action; and

(4) one feels able to effectively carry out the recommended actions.

Drawing upon these principles, *ARREST* first educates teens about HIV infection and risk-related behaviors and then fosters the development of risk reduction skills. Additionally, because Social Learning Theory links learning to repeated observation and imitation, the program instructor serves as a model of socially desirable behaviors. After students observe their instructor engage in successful communication and decision-making, they practice these skills in a series of role-play exercises.

Program Objectives

As an HIV/AIDS risk reduction program, *ARREST* is designed to meet the following educational objectives:

(1) to provide information about HIV transmission and prevention;

(2) to teach youth how to purchase and properly use condoms with nonoxynol-9 spermicide;

(3) to teach youth how to evaluate their level of risk and identify situations that are associated with risk behaviors;

(4) to foster the development of decision-making, communication and assertiveness skills for coping effectively with peer pressure and high-risk situations; and

(5) to establish peer support groups encouraging HIV prevention and risk reduction behaviors.

Program Schedule

During the original field study, *ARREST* participants met for five 90-minute sessions, but the first and final meetings were dedicated to the pre- and post-test evaluation assessments. Although all five sessions are included in the manual, instructors should note that only the second, third, and fourth are actual *training modules* for *implementing* the program.

Each training module begins with a 30-minute discussion of students' questions, followed by review and reinforcement of the material and take-home exercise from the previous session. During the remainder of the lesson, new material is presented. In the field study, participants were paid $5 at the conclusion of each of the sessions, and an additional $5 if they attended all of the meetings. You can decide whether you wish to follow a similar procedure with your teens.

In the field study, each participant was given a blank notebook that served as a reflective journal. Although the curriculum includes a few assigned exercises, teens were encouraged to use the journal for recording their thoughts and feelings outside of the program as well. They might also express themselves by drawing pictures or writing poetry. Feel free to modify or expand the use of the journals in your own implementation of the program.

Description of Training Modules

TRAINING MODULE 1: AIDS Education

This session provides participants with basic information about AIDS and HIV infection, including transmission, prevention, treatment and testing. By the end of the lesson, participants should understand four essential concepts.

(1) AIDS is an infectious disease that has reached epidemic proportions within the United States and throughout the world. AIDS is caused by the human immunodeficiency virus.

(2) AIDS is a very difficult disease to contract. There are very specific ways in which people become HIV infected—through sexual intercourse with an infected person, sharing intravenous drug use equipment with an infected person or perinatally, from an infected mother to her newborn child.

(3) There is no effective form of treatment or vaccine against HIV infection. Prevention and risk reduction are the only means for protecting oneself.

(4) Effective prevention requires either abstinence from sexual intercourse and needle sharing, or risk reduction by consistent

use of condoms during sexual intercourse and sterilizing equipment before drug use.

TRAINING MODULE 2: Instruction on How to Properly Use and Purchase Condoms

This session provides participants with specific information about risk-related behaviors and preventive measures, including the effectiveness of various condoms, how and where to buy condoms, how to prevent condoms from breaking, leaking or slipping off and how to effectively use condoms and spermicide. Participants learn that effective prevention requires that they either delay or abstain from risk-related sexual and drug use behaviors, or that they use condoms and spermicide each time they engage in oral, vaginal or anal intercourse, and avoid needle sharing. By the end of the session, participants should understand and identify their own risk-related behaviors and set goals for future prevention and risk reduction.

TRAINING MODULE 3: Decision-Making, Communication and Assertiveness Skills Training

Adolescents' desire to be liked by their peers and uncertainty about their own feelings and beliefs make it all the more difficult for them to resist peer pressures. This *ARREST* module has been designed to help participants learn how to discuss HIV prevention and risk reduction with friends or sexual partners and how to resist peer pressure. Through role play and group discussion, the program leaders first demonstrate and then invite students to practice avoiding sexual pressures by communicating positively and assertively. The following communication skills are discussed:

- assertive talk: how to assertively communicate one's rights;
- expressing feelings: how to recognize and express feelings in an appropriate and skillful manner;
- making a request: how to be clear, direct and positive;
- coping with refusal: how to handle situations when requests result in refusals, such as when one's boyfriend refuses to use a condom during intercourse;
- refusing a request: when someone makes an unreasonable request (e.g., for unprotected sex or sharing unclean needles), one should acknowledge the person's needs, but say "no;"

- showing appreciation: how and when to reinforce appropriate behaviors, such as requests to use STD protection; and
- skills for resisting peer pressure: how to respond to peer pressure using effective assertiveness and communication techniques.

Program Materials: Replicating or Adapting *ARREST*

Curriculum Manual

ARREST can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of the book. The program package includes the *ARREST Curriculum Manual.* The manual provides detailed plans for leading each of the program sessions. Also included are sample scripts for facilitating group discussions and descriptions of the homework activities. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

AIDS Awareness Form

In the field study of the program, this form was distributed to all participants following the pre-test assessment. The youth were asked to spend a few minutes writing down their thoughts about HIV/AIDS and bring the form with them to the first training session.

Additional Materials

The PASHA program package provides everything needed to implement the *ARREST* program, except for the following materials, which should be available in your school or community-based organization: condoms, lubricant and foam spermicide (needed for demonstration and practice during Training Module 2); pieces of colored felt, magazines, envelopes, index cards, pencils and paper.

In addition, in the original field study, each participant was given a small blank notebook in which to record their thoughts, feelings and behaviors throughout the program. Suitable books should be available at a neighborhood stationery store.

How to Implement the Program

ARREST should be taught by skilled AIDS educators, with one teacher leading each group of 10 to 12 students. Educators should know how to lead group discussions, facilitate role-play interactions and conduct demonstrations. They should also be able to effectively model the communication and assertiveness skills they are trying to teach. Finally, it is important to thoroughly review the *ARREST Curriculum Manual* prior to the start of the first session.

Ground Rules for Group Discussions

Listed below are five ground rules to guide your group discussions. Following these rules will help to establish an atmosphere of mutual trust and support during the program.

- Everything that is mentioned during the sessions is confidential.
- All participants can choose what thoughts and actions they wish to share and which ones they prefer to keep private.
- All questions are good questions, and all comments are worthy of consideration.
- All participants are expected to listen actively to one another.
- At the same time, all students are expected to show respect for one another. Talking about others' comments outside of the group discussion, or teasing or insulting others will not be tolerated. Different opinions should be respected.

The Use of Journals

At the start of the program, each participant should be given a blank journal. The journals will be theirs to keep even after the program ends. Present the journals with the following introduction.

- Many teens already record their thoughts and feelings in journals or diaries. For others, this will be a new experience.
- Journals provide a safe, private place to express your thoughts. Keep your book in a place where others will not find it.
- People often write in their diaries, but you can also draw pictures or compose music or poetry. Some teens write letters to relatives, friends or pets. Use whatever method works best for you!

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the *AIDS Risk Reduction Education and Sills Training Program* was investigated in a field study conducted in New York City in 1989. The study compared participating teens with a control group of youth on a waiting list for the program. The researchers investigated the two groups' HIV/AIDS-related knowledge, attitudes, perception of risk, self-efficacy about avoiding risky situations, as well as their actual sexual behavior. Surveys and role-play assessments were administered to all teens at two points:

- Time 1: at the start of the intervention (pre-test); and
- Time 2: immediately after the intervention (post-test).

Evaluation Questions

The researchers hypothesized that *ARREST* participants would show significant gains in HIV/AIDS-related attitudes, knowledge and behavior, relative to their control group peers. In particular, program participants were expected to show:

(1) increased knowledge and understanding of HIV/AIDS, including perceptions of their own risk of infection;

(2) greater self-efficacy, or belief in their own ability to follow preventive behaviors; and

(3) enhanced assertiveness and communication skills for negotiating prevention and risk reduction and resisting peer pressure.

Data Collection Procedures

Teens were recruited for the study from three agencies providing alternative education and after-school programs for at-risk youth, ages 12 to 16, in New York City. To attract participants, program staff posted flyers, sent letters home and met with students and teachers to describe the study. The only requirements for eligibility were the ability to speak English and provide written consent from parents.

Potential participants were assured that all information provided during the study would be confidential. In addition, each teen would receive $5 at the end of each session, plus an additional $5 if they attended all five sessions, for a maximum of $30. Following recruitment, volunteers were randomly assigned either to an *ARREST* intervention group or to a waiting list for the program. The assessments took place during the first and final program sessions.

Research Sample

The final sample included 87 teens, ages 12-16, who were considered to be at elevated risk for HIV infection. Of this group, 39 were male (45%) and 48 were female (55%). In addition, more than half of the youth were Latino (59%), and the remainder were African-American (41%).

Evaluation Results

Time 1 Assessment

At the start of the study, the researches found no significant differences between the two groups of teens. Overall, 28 of the 87 teens were sexually active. Of this group, 12 reported having had sex during the month before the pre-test, with an average of 5 sexual encounters and 2 sexual partners during that time. Moreover, males were significantly more likely than females to be sexually active. In addition, two females reported having been pregnant and one male had contracted a sexually transmitted disease.

Time 2 Assessment

One month after the intervention, program participants showed a significant increase in their knowledge about HIV/AIDS ($p<.001$) and in their perceptions of adolescents' risk of infection ($p<.01$), relative to their control group peers. *ARREST* participants also showed a significant decrease in negative attitudes about AIDS ($p<.05$).

In addition, on the role-play assessments of behavioral skills, teens who participated in the *ARREST* program demonstrated significantly greater skill in refusing to engage in risk-related activities ($p<.001$) and in proposing alternative lower-risk activities ($p<.001$), relative to their control group peers.

However, the two groups of teens did not differ on measures of self-efficacy or sexual behavior (e.g., number of sexual encounters, number of sexual partners and condom use).

Summary

Overall, *ARREST* appeared to be effective in meeting its short-term objectives for improving teens' knowledge and behavioral skills, two important prerequisites for behavior change. Following their exposure to the three-session program, *ARREST* participants showed significant gains in their knowledge and attitudes about HIV transmission and prevention, perceived risk and appropriate concern about infection. Participation in the program was also associated with greater skill in discussing and negotiating HIV prevention and risk reduction, and in resisting coercive pressures to engage in unprotected sexual intercourse. Yet, program participation did not appear to have any impact on teens' perceived self-efficacy regarding preventive behaviors, nor in reducing their involvement in unprotected sexual intercourse.

In interpreting the findings, the researchers suggest a number of reasons for the absence of any behavioral change among youth. First, teens' patterns of sexual activity were measured immediately after the intervention, and this short period of time may have been insufficient for registering change. The relatively small sample size may also have hampered efforts to measure statistically significant outcomes. Finally, the brief duration of the *ARREST* intervention may have limited its effect on teens.

Moreover, the brief follow-up period makes it difficult to attribute positive outcomes to participation in the program. The researchers recommend additional studies with longer follow-up periods to better understand the effectiveness of the intervention—not only on teens' knowledge, attitudes and skills, but on their risk-related behaviors as well.

Evaluation Materials for *ARREST*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments*, the *Prevention Minimum Evaluation Data Set (PMEDS)* and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in its new sites, with new groups of teens.

Original Evaluation Materials

Included in the *Original Evaluation Instruments* are the questionnaire and role-play scenarios used in the field study of the *ARREST* program. The same battery of measures can be used for both assessment periods.

Knowledge, attitudes and beliefs survey. Following a few background demographic questions, this survey includes measures of HIV-related knowledge, attitudes and beliefs; perception of risk; self-efficacy; and involvement in HIV risk-related sexual and drug-use behaviors.

Please note that the survey includes numerous items assessing high-risk behaviors, such as intravenous drug use, age of first intercourse, involvement in opposite or same-sex intercourse, prior intercourse with an intravenous drug user or homosexual/bisexual male, prior pregnancy or infection with a sexual transmitted disease and patterns of contraception/STD protection. You may want to consider the suitability of such measures for use with your teens.

Role-play assessment. In the field study of the program, role-play assessments were used to measure participants' decision-making, assertiveness and communication skills. Students were asked to respond to three situations; their responses were videotaped for subsequent coding and analysis. The situations involve:

(1) a dating situation where a boy-/girlfriend proposes a sexual encounter;

(2) a situation where a boy-/girlfriend of five months (or more) asks to start using birth control pills rather than condoms; and

(3) a coercive situation where a sexual partner is pressuring the adolescent to engage in unprotected intercourse.

Different sets of role-play situations are provided for males and females, although both call for similar responses.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *ARREST*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants of teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

16

AIDS Risk Reduction for College Students

An STD/HIV/AIDS Prevention Program

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Program Abstract

Title

AIDS Risk Reduction for College Students

Summary

Designed as a workshop for college students, this program consists of three two-hour sessions that are based on Fisher and Fisher's Information-Motivation-Behavioral Skills approach to AIDS risk reduction. The informational component includes "AIDS 101," a slide show that explains transmission and prevention of HIV, testing for the virus and the need for sexually active individuals to use condoms for protection against HIV/AIDS. In the motivational component, small-group discussions are led by a peer health educator and participants view a video narrated by persons who contracted HIV through unsafe sexual intercourse. Finally, the development of behavioral skills is encouraged through role plays of safer sex communication.

In a field study of the program with 744 college students, participants showed significant gains in knowledge, motivation and behavior. In particular, sexually active participants were more likely than similar control students to purchase and use condoms during a two- to four-month period following the intervention.

Focus

☐ Primary pregnancy prevention
☐ Secondary pregnancy prevention
☑ STD/HIV/AIDS prevention

Original Site

☑ School-based
☐ Community-based
☐ Clinic-based

Suitable for Use In

This program is most appropriate for older adolescents and young adults, ages 18-22. It can be used in a college setting or a community-based organization.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach

☑ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☐ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age	A total of 744 college students participated in the study; their median age was 20.
Gender	49% male, 51% female.
Race/ Ethnicity	88% White, 3% African-American, 3% Latino, 4% Asian, 1% other.

Program Components

☐ Adult Involvement
☐ Case Management
☑ Group Discussion
☑ Lectures
☑ Peer Counseling/Instruction
☐ Public Service Announcements
☑ Role Play
☑ Video
☑ Other slide show

Program Length

The program consists of three two-hour sessions spaced (about) a week apart.

Staffing Requirements/ Training

The program is led by a health educator and several peer educators (one peer educator for approximately 5-6 students). Peer educators take part in an extensive training session covering basic facts about HIV/AIDS, as well as strategies for leading role plays and facilitating small group discussions. A comprehensive training curriculum is presented in the *AIDS Risk Reduction for College Students Peer Educator Training Manual* included in the PASHA program package.

It is recommended that the health educator have a Masters degree in psychology, public health or a related field, as well as significant experience leading HIV prevention programs.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

Because college students engage in exceedingly high levels of unprotected sexual intercourse, often with multiple partners in a serially monogamous pattern, they are at considerable risk for infection with HIV and other sexually transmitted diseases (STDs). *AIDS Risk Reduction for College Students* was designed using Fisher and Fisher's Information-Motivation-Behavioral Skills (IMB) model of AIDS risk behavior change to reduce HIV risk-related behaviors among male and female college students. The intervention curriculum is specifically designed to address deficits in AIDS risk reduction information, motivation and behavioral skills that are common among university students.

The program consists of three two-hour workshop sessions, which are conducted by a health educator and a team of peer educators. Workshop sessions attempt to provide students with accurate knowledge regarding HIV transmission and prevention, motivation to adopt HIV preventive behaviors, as well as the behavioral skills and confidence to execute and maintain risk reduction behaviors.

This intervention was originally implemented and field tested with a group of undergraduate dormitory residents at the University of Connecticut. The development, implementation and scientific evaluation of *AIDS Risk Reduction for College Students* was funded by the National Institute of Mental Health and by awards from Health & Welfare Canada and Janssen-Ortho.

Theoretical Framework

AIDS Risk Reduction for College Students is based on Fisher and Fisher's Information-Motivation-Behavioral Skills (IMB) model of AIDS risk behavioral change. The IMB model holds that in order to initiate and maintain changes in AIDS risk behavior, individuals must have: (1) accurate information regarding AIDS transmission and prevention; (2) motivation—based on social norms and expectations, or feelings of personal vulnerability—to utilize that information; and (3) the necessary behavioral skills and confidence in one's ability (self-efficacy) to perform specific preventive acts.

The researchers designed the program in three phases. First, they determined the target population's pre-intervention levels of AIDS risk reduction information, motivation, behavioral skills and HIV risk and prevention behavior. Then they developed program activities that would address the deficits they had identified in each of these areas and facilitate AIDS risk behavior change. Finally, rigorous evaluation research was employed to determine the extent to which the IMB model-based intervention produced short and longer term changes in college students' AIDS risk reduction information, motivation, skills and behavior.

Program Objectives

The goal of *AIDS Risk Reduction for College Students* is to reduce college students' risk of infection with HIV/AIDS and other sexually transmitted diseases (STDs). Specifically, the program is designed to achieve the following objectives:

- to increase students' knowledge regarding HIV/AIDS risk and transmission and dispel commonly-held "myths" (e.g., unprotected sex is okay if you know your partner's sexual history);
- to increase students' awareness of their personal vulnerability to HIV infection;
- to positively influence students' AIDS prevention attitudes and perceived social norms;
- to increase students' levels of AIDS prevention behavioral skills; and
- to increase safer sexual practices among sexually active students, including consistent and correct use of condoms and HIV antibody testing.

Program Overview

The *AIDS Risk Reduction for College Students* program consists of three, two-hour workshop sessions designed to be implemented approximately one week apart. The program includes three components—informational, motivational, and behavioral skills—which are interspersed across the three sessions. An overview of the program appears below.

Health and Peer Educators

In the original field study, the intervention was implemented in a workshop entitled "Sex in the 90s: Pleasures, Problems, and Prospects." Sessions were conducted in a dormitory setting by a team of one health educator and five peer educators. Peer educators were selected for their ability to act as natural opinion leaders and influence norms and attitudes about HIV prevention; they were also expected to serve as role models. All peer educators took part in an intensive four-day training session.

During the intervention, the peer educators guided small group discussions. The discussions addressed:

- attitudes toward preventive behaviors (e.g., buying, carrying and using condoms; communicating with partners about HIV-preventive behavior, undergoing HIV antibody testing);
- ways to address negative aspects of preventive behaviors (e.g., using a lubricant to improve sensation with condoms); and
- HIV prevention norms, expectations and behavior.

Informational Component

The information component of the intervention consists primarily of a slide show ("AIDS 101") addressing college students' performance of AIDS preventive behavior. The slide show, which is narrated by the health educator, utilizes considerable humor, and is heavily illustrated. It includes information on HIV transmission and prevention, the relative risk of different behaviors, the effectiveness of condoms, where to get condoms and HIV antibody testing. The slide presentation also debunks incorrect AIDS prevention strategies and risky safer sex decision rules (e.g., not needing to use a condom if you are monogamous or only have sex with "nice" partners). Following the slide presentation, the health educator further addresses and corrects "myths" about HIV prevention and transmission, including faulty decision rules and assessments of partner risk.

Motivational Component

This component is designed to influence students' attitudes and perceived social norms regarding AIDS preventive behaviors, as well as perceptions of their personal vulnerability to HIV infection. Peer educators lead discussions with small groups (four to six students) that are designed to influence attitudes and social norms regarding HIV prevention behaviors. Large group discussions, led by the health educator, are designed to promote social expectations and support for safer sexual behavior. Also included in this component is the video *People Like Us,* which is designed to heighten students' perceptions of personal vulnerability to HIV infection. Interviews with six attractive men and women introduce viewers to HIV+ individuals who are similar to the program participants in terms of age, appearance, sexual history and sexual orientation. All contracted HIV due to unsafe sexual behavior. The video also attempts to influence attitudes toward safer sexual behaviors by stressing that the discomforts of condom use are minor relative to the consequences of contracting HIV/AIDS.

Behavioral Skills Component

The final program component teaches students how to effectively initiate and maintain safer sexual behavior, even in particularly challenging situations. Program participants view a video (*Sex, Condoms and Videotape*) produced especially for this intervention. The video uses a soap opera format to humorously depict four types of couples (ranging from a several-month relationship to an inebriated couple planning a one-night stand) who successfully practice safer sex and overcome common impediments to safer sex. A discussion and role play of specific scripts for effective safer sex communication follow the video presentation. All students—male and female—take turns putting a condom on a life-like model of an erect penis. Finally, participants are given a behavioral homework assignment.

Program Materials: Replicating or Adapting *AIDS Risk Reduction for College Students*

The *AIDS Risk Reduction for College Students* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of the book. The program package includes the following materials needed to implement this program in your college or university. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Session Guides

The *AIDS Risk Reduction for College Students Session Guides*. This binder contains comprehensive guides for the three program sessions. Each guide includes an outline, list of required supplies, homework, evaluation forms and suggested scripts for facilitating the session. At the back of the binder are the slides for the *AIDS 101* slide show. Masters of handouts for all three sessions are found in the *Handout Masters for Session Guides*.

Peer Educator Training Manual

The *AIDS Risk Reduction for College Students Peer Educator Training Manual*. This binder contains a comprehensive manual for the four-day peer educator training program. It includes an overview of the IMB model and the intervention; a description of the role of the peer educator; quizzes; and extensive training and practice in facilitating small group discussions, leading role play exercises and answering difficult questions. Masters of all handouts needed for the training program are found in the *Handout Masters for Peer Educator Training*.

Audio-Visual Materials

People Like Us. This video, shown during the first program session, is designed to increase students' perceptions that HIV prevention is relevant to them. It includes six interviews with people who are

HIV+. Most are young and heterosexual, and all were infected with HIV through sexual contact. The video is accompanied by a brief *Instructor's Manual* to facilitate discussion of the material.

AIDS 101. This slide show contains 54 slides presenting basic information on HIV/AIDS. Shown in the first program session, it covers a range of topics, including routes of HIV transmission, risk-related behavior and strategies for reducing risk. The slides can be found in the back of the *Session Guides* binder.

Sex, Condoms and Videotape. This 24-minute videotape, shown in the second session, humorously depicts four couples who successfully practice safer sex by overcoming common impediments faced by university students. A brief *Instructor's Manual* provides additional information and discussion questions relevant to the video.

People Like Us: A Reprise. This 7-minute video contains messages from the HIV+ people interviewed in the video shown during the first session. It is the final activity of Session 3.

Pamphlets and Brochures

The following pamphlets are distributed to students in a folder at the beginning of Session 1.

HIV Infection and AIDS: What Everyone Should Know. This pamphlet defines HIV and AIDS and describes modes of transmission and methods of preventing infection.

The HIV Antibody Test. This pamphlet describes the HIV antibody test, and the meaning of positive, negative, false positive and false negative results. Guidelines are provided for deciding whether one should be tested, and anonymous testing is encouraged.

Making Sex Safer. This pamphlet describes the symptoms and treatments for seven common STDs (including HIV) and problems that may result if each disease is left untreated. It also discusses the risk levels of various sexual behaviors; encourages the use of condoms; and discourages sex under the influence of drugs or alcohol.

How to Use a Condom. This one-page guide lists a series of "Do's and Don'ts" with regard to purchasing and using condoms. It also suggests several responses to complaints from an unwilling partner.

The Rubber Tree. This catalog from Zero Population Growth of Seattle offers a vast array of condoms, lubricants, spermicides and other safer sex supplies (e.g., dental dams).

Books and Articles for Training Peer Educators

In the original field study of the program, peer educators were required to read the following books and research articles in order to receive course credit for the training program. While these readings provide valuable background information, the original program developers feel they play a supplementary role in the training curriculum.

The two texts below are included in the PASHA program package.

American Red Cross HIV/AIDS Education Instructor's Manual (1990). This manual provides extensive information about HIV transmission, prevention and educational strategies.

Bao, D. & Thorne, B. (1991). *Condom Educator's Guide.* This guide reviews different types of condoms, condom usage, lubricants and resources in an entertaining fashion.

The journal articles listed below should be available in your university library, should you choose to use them in your own intervention.

Johnson, R.W., Ostrow, D.G., & Joseph, J. (1990). *Educational strategies for prevention of sexual transmission of HIV.* An overview of HIV education strategies is presented.

Can you rely on condoms? (1989, March). This report presents the results of condom reliability and testing.

Williams, S.S., Kimble, D.L., Covell, N.H., Weiss, L.H., Newton, K.J., Fisher, W.A., & Fisher, J.D. (1992). *College students use implicit personality theory instead of safer sex.* In this article, the authors present the results of focus group research on common misconceptions regarding the necessity of condoms with sex partners.

Lifson, A.R. (1988). *Do alternate modes of transmission of human immunodeficiency virus exist?* This review summarizes research findings regarding alternate modes of HIV transmission, including insect bites and casual contact.

Reiss, I.L., & Leik, R.K. (1989). *Evaluating strategies to avoid AIDS: Number of partners vs. use of condoms.* This article addresses the relative effectiveness of different HIV risk reductions strategies, such as using condoms vs. reducing the number of sexual partners.

Additional Materials

The PASHA program package provides everything needed to implement *AIDS Risk Reduction for College Students*, except for the following materials that should be available in your school or community: a TV and VCR, 35 mm slide projector, photocopier, an extension cord, condoms and penis models, name tags, tape, pens/pencils, chalkboard or flip chart and markers, clipboards, props for the role plays (grocery bags, Twinkies, box of condoms, remote control) and snacks. In addition, you should prepare a handout listing the addresses and phone numbers of nearby HIV testing facilities and places where students can purchase condoms to be distributed with the pamphlets in Session 1. In the original field study, the peer educator training curriculum included a set of supplementary readings. They should be available at your university library, should you choose to use them for your own intervention. In the original field study of the program, each student received a safer sex packet at the end of Session 3, with a condom key chain, a variety of condoms and some lubricant. You may want to prepare safer sex packets for your program.

How to Implement the Program

Using the *Session Guides*, a health educator and several trained peer educators should have no trouble effectively implementing the *AIDS Risk Reduction for College Students* program.

Selecting a Health Educator

Ideally, the health educator should have a Masters degree in psychology, public health or a related field. However, an individual with significant training and experience presenting AIDS education programs might be equally suitable for the position. The following knowledge, skills and abilities are also essential:

- extensive experience and training in facilitating group sessions;
- training in or understanding of behavioral science research;
- high level of comfort speaking about sexual issues;
- strong organizational and supervisory skills;
- ability to communicate ideas with energy and charisma;
- in-depth knowledge of HIV transmission and prevention, including awareness of current research and controversies; and
- ability to be non-judgmental and remain focused on HIV prevention issues during group discussion.

Moreover, the health educator will need to help the peer educators feel excited about the *AIDS Risk Reduction for College Students* program; believe they can succeed in making a difference; feel (and work as) part of a team; and see through difficulties that will inevitably arise during the intervention. Patience, a sense of humor and flexibility will prove tremendously helpful.

Selecting and Training Peer Educators

The peer educators must be trained well in advance of the first program session. The PASHA program package contains a comprehensive, self-explanatory peer educator training manual. The training spans four 1-day sessions; however, holding these sessions on four consecutive days proved to be grueling for peer educators and trainers in the original field study. Therefore, it is advisable to hold sessions once a week over a month, or even once every 2-3 weeks over the summer.

In the original field study of the program, the peer educators took written and oral exams based on the materials and concepts covered in the curriculum. You may also want to do this in your training program. The *Peer Educator Training Manual* includes three short quizzes, but no longer exams.

Strive to have one trained peer educator for every five to six students participating in your program. Though unfortunate, it is unlikely that all who volunteer to serve as peer educators will complete the training satisfactorily. It is a good idea to recruit more trainees than you will need and expect that some will drop out or not adequately master the required skills.

Session Guides

Once peer educators have been trained, turn to the *Session Guides* and read through them carefully. The guides, which are quite extensive, include:

- an outline and list of supplies for the session;
- a overview of session logistics;
- suggested scripts for virtually everything you (the health educator and peer educators) might say during the session;
- comments and suggestions for the session;
- group worksheets and homework assignments; and
- session evaluation forms.

You should feel free to customize the scripts to suit your particular group of college students, but the prepared scripts provide a useful starting point for: (1) introducing the program; (2) introducing the slide show; (3) narrating the slide show; (4) introducing the videos; and (5) initiating group discussion after the videos.

Addressing Relationship Issues

During the original field study of *AIDS Risk Reduction for College Students,* many participants feared that their relationships would be threatened by discussions of safer sex. The program developers found that it was important to confront students' concerns about relationship conflict that may be precipitated by discussion or institution of safer sexual practices. The psychological discomfort associated with viewing one's sexual partner as a potential health threat must also be addressed. Including both members of the couple and providing concrete examples of ways in which to deal with relationship issues may further enhance the effectiveness of the program.

Evaluating the Program

The Original Evaluation

Design

The field study of *AIDS Risk Reduction for College Students* was conducted with a group of undergraduate dormitory residents at the University of Connecticut. Individual dormitories were randomly assigned to serve as experimental and control dormitories. Dormitories assigned to the treatment condition received the three-session intervention over a three-week period; floors assigned to the control condition received no intervention. Both treatment and control groups were assessed at three points in time:

Time 1: Immediately preceding the program (pre-test);

Time 2: One month following the program (post-test); and

Time 3: Two to four months following the program (follow-up).

Evaluation Questions

The evaluation was designed to assess the program's effects on AIDS information, motivation, behavioral skills and risk behaviors.

Specifically, the field study addressed the following questions.

(1) Did participation in the *AIDS Risk Reduction for College Students* program increase students' STD/HIV/AIDS-related *knowledge*?

(2) Did program participation increase students' *motivation* to implement safer sexual practices?

(3) Did participation in the program increase students' AIDS risk reduction *behavioral skills*?

(4) Did program participation increase students' performance of AIDS risk reduction *behaviors*?

Intervention and Control Groups

Four quadrangles of high rise dorms with alternating floors of males and females were randomly selected to participate in the field study. Within each quadrangle, individual dormitories were randomly assigned to serve as experimental or control dorms. Within each type of dorm, a female floor was randomly selected for research participation and paired with the male floor above or below with which residents had the closest social ties. The sets of linked female-male floors composed the experimental and control group units.

This design allowed the intervention to be delivered in a mixed sex context and among groups of students who already knew and interacted with one another. In this way, it was hoped that participation might encourage students to change their perceptions (and behaviors) within their natural social networks.

Data Collection Procedures

Students in the experimental and control group units were recruited and paid $10.00 to complete a pre-test that assessed pre-intervention levels of AIDS risk reduction information, motivation, behavioral skills and behavior. The pre-test was distributed at organizational meetings held by each dormitory floor at the beginning of the semester. Students were told that the pre-test was part of a longitudinal survey of college sexual behavior sponsored by the National Institute of Mental Health (NIMH). Later in the year, the researchers added, the students would be re-contacted asked to complete additional NIMH surveys.

Students residing on treatment floors were later recruited to participate in the intervention, which was described as a dormitory workshop on sexuality and relationships. Investigators attempted to minimize the possibility that program participants would connect the intervention to the evaluation measures by having separate sets of individuals describe the pre-test and workshop. All treatment floor residents who completed the pre-test were invited to complete subsequent questionnaires, although not all of them chose to participate in the program. The intervention consisted of three two-hour sessions held one week apart.

Students living on control floors received no intervention, but they were asked to complete the identical pre-test, post-test and follow-up measures at the same time as treatment floor students. The post-test, which assessed risk reduction information, motivation, behavioral skills and AIDS preventive behavior, was administered independently to experimental and control dormitory floors four weeks after the final intervention session. Two to four months following the final intervention session, participants completed the follow-up assessment, focusing on AIDS risk reduction behavior.

Sample

A total of 744 undergraduate dormitory residents (362 males and 382 females) at the University of Connecticut completed the pre-test. Students' median age was 20, and 88.3% were White, 2.7% African-American, 3.4% Hispanic, 4.3% Asian and 1.2% were of "other" racial/ethnic background. The sample was predominantly heterosexual, with 4% of the males and 2% of the females reporting a history of same-sex sexual behavior. Of those who completed the pre-test, 658 completed the post-test, and 570 completed the follow-up measure.

Measures

The Time 1 and Time 2 assessments included measures of AIDS risk reduction information, motivation, behavioral skills and engagement in AIDS risk and AIDS preventive behavior. The follow-up assessment focused on levels of AIDS risk and AIDS preventive behavior. All of the instruments were self-administered.

Analytic Method

In the original field study, university students living on adjacent male and female dormitory floors composed units that were randomly assigned to treatment and control conditions. Because individuals within particular treatment or control group units were likely to interact with one another socially between the pre-, post- and follow-up measures, they may have influenced one another's responses to the surveys. Therefore, it could not be assumed that the data points for individual participants within a group would be independent of the data from other participants within the same group. As a result, the program evaluators adopted a data analysis strategy that could estimate the intervention effects at both the individual and group levels.

Evaluation Results

To be included in the analysis, treatment group participants had to have attended all three intervention sessions and to have completed both the pre- and post-test measures; control participants had to have completed the pre- and post-test measures. In all, 521 participants met these requirements. At the start of the program, no significant differences were found between treatment and control participants on levels of AIDS risk reduction information, motivation, behavioral skills or behavior.

In addition, the researchers found no significant differences between treatment floor residents who completed all intervention session and those who either refused to participate or who dropped out. Similarly, no significant differences were found between treatment and control students who completed the post-test and follow-up measure and those who did not.

Measures of Information, Motivation and Skills

AIDS Risk Reduction Information

Participation in the *AIDS Risk Reduction for College Students* program produced significant increases in AIDS prevention information. Post-intervention scores on both measures of the information construct were significantly higher than those prior to the intervention. This increase was apparent at both the individual ($p<.001$) and group levels ($p<.001$).

AIDS Risk Reduction Motivation

The intervention had a significant effect on two of three measures of AIDS risk reduction motivation. While attitudes toward the performance of AIDS preventive behavior and intentions to engage in such behavior were significantly improved among program participants one month following the intervention, the intervention had no reliable effect on social norms. The intervention effect for attitudes was significant at both the individual ($p<.0001$) and group ($p<.005$) levels, while the effect for behavioral intentions only approached significance ($p=.059$) at the group level.

Thus, while the intervention significantly improved attitudes toward performing AIDS preventive behavior and intentions to engage in such behavior, it had no reliable effect on students' perceptions of social norms. Program evaluators offered two possible explanations why the intervention had no impact on participants' perceptions of social support for safer sexual behavior. First, the intervention may not have been successful at actually changing students' social norms. Alternatively, it is possible that the evaluation measures did not adequately assess perceived changes in peer social norms.

AIDS Risk Reduction Behavioral Skills

AIDS Risk Reduction for College Students significantly increased participants' perceptions of the effectiveness and ease with which they could enact critical AIDS preventive behaviors. Compared to control group members, program participants showed significantly higher scores on both indicators of behavioral skills. For the efficacy construct, the scores were significant at both the individual level ($p<.0001$) and the group level ($p<.005$); for the difficulty construct, the scores were significant both at the individual ($p<.0001$) and group level ($p<.05$), as well.

Measures of AIDS Risk Behavior

To be included in the analysis of intervention impact on AIDS risk behavior change, treatment students had to have attended all three intervention sessions and completed the pre-test, post-test, and follow-up measures of AIDS preventive behavior. In addition, students had to be individuals for whom self-initiated behavioral change or maintenance of such change was necessary (i.e., they had to have been sexually active; to have had a partner who had not already insisted on the practice of safer sex; could not have indicated that both they and their partner had been each other's only lifetime sexual partner; and could not have indicated that both they and their partner had tested negative for HIV). Each of these criteria had to have been met at each of the three measurement intervals. In all, 134 students met these criteria.

The intervention produced consistent, positive changes in almost every indicator of AIDS risk prevention behavior, as explained below.

Safer Sex Discussion

Program participants reported higher levels of discussing AIDS preventive behavior with a sexual partner. This effect was significant at both the individual and group levels one month following the intervention; however, this effect was not significant at either level at the two to four month follow-up assessment. A potential explanation for this finding is that intervention participants may have discussed safer sex with their partners early on, decided upon behavior change, and therefore did not need to discuss the matter further at the time of the follow-up assessment.

Condom Accessibility and Use

The intervention also had a significant effect on condom accessibility and use. Compared to their peers in the control group, program participants were more likely to buy condoms and have them available at both one month post-intervention and two to four months post-intervention. This effect was significant at both the individual and group levels.

In addition to increasing condom accessibility, the intervention also produced sustained increases in condom use. Program participants showed significantly greater levels of condom use than control group participants at both the one month post-test assessment and the two to four month follow-up. The post-test indicator of condom use can only be interpreted at the group level, and it was significant ($p<.05$), showing that the intervention increased condom use. At the two to four month follow-up, condom use can be interpreted at the individual level, and was significant ($p<.005$). Thus, the intervention resulted in an increase of the critical AIDS preventive behavior of condom use, which was sustained over the follow-up period.

HIV Antibody Testing

Finally, while the intervention had a significant effect at the individual level on increasing HIV antibody testing behavior at the follow-up, program evaluators assert that this effect should be interpreted with caution. Because individual data do not appear to be independent from group data, this effect is more reliably interpreted at the group level.

Summary

The evaluation showed that the three-session *AIDS Risk Reduction for College Students* program can be effective in changing risky sexual behavior in a college student population. The IMB model-based intervention produced increases in multiple indicators of AIDS risk reduction information, motivation and behavioral skills, as well as sustained increases in AIDS preventive behavior.

One month following the intervention, program participants showed significant increases in AIDS risk reduction knowledge, motivation and behavioral skills, as well as significant increases in AIDS preventive behaviors, such as having condoms accessible, using them and engaging in safer sex negotiations, all relative to their control group peers. At the follow-up assessment (two to four months after completion of the intervention), program participants again showed significant increases in AIDS risk reduction behaviors, including keeping condoms accessible and using them during intercourse.

An important observation from the field study concerns the potential obstacles to safer sexual practices that are posed by relationship partners. The program evaluators noted that participants often reported that it was a major challenge to initiate and maintain AIDS risk behavior changes with their relationship partners (who were not participants in the intervention). Concern about relationship conflict precipitated by discussion or institution of safer sexual practices and the dissonance, or psychological discomfort, associated with viewing one's sexual partner as a potential health threat were significant obstacles for students. In future implementations of the program, it may be helpful to include couples and explicitly address factors in relationships that may impede AIDS risk behavior change.

Evaluation Materials for *AIDS Risk Reduction for College Students*

In addition to the program materials described in an earlier section, the PASHA program package includes three resources for evaluation: the questionnaire used in the original evaluation, the *Prevention Minimum Evaluation Data Set* and the *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

The questionnaire used in the original evaluation of the program is provided in the packet entitled *Original Evaluation Instruments*. This questionnaire, *A Measure of AIDS Prevention Information, Motivation and Behavioral Skills*, is a self-administered instrument assessing students' knowledge of AIDS transmission and prevention; their motivation for performing AIDS preventive behavior; the perceived difficulty and their perceived effectiveness in performing AIDS preventive behaviors; and measures of AIDS preventive behavior (i.e., safer sex discussion, condom accessibility, condom use during sexual intercourse and HIV antibody testing). The same instrument can be used for the pre-test and follow-up assessments.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *AIDS Risk Reduction for College Students*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants of teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

17

A Clinic-Based AIDS Education Program for Female Adolescents

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Bibliography

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Program Abstract

Title

A Clinic-Based AIDS Education Program for Female Adolescents

Summary

This is a single-session group intervention originally targeted toward sexually active girls between 13 and 21 years of age. The session includes a brief lecture on transmission and prevention of HIV/AIDS (based on CDC guidelines), followed by a video demonstrating the purpose and use of condoms. As the session ends, participants receive an educational booklet reinforcing the program's lessons and coupons that may be redeemed anonymously for an unmarked box of condoms at a local pharmacy. The redemption rate of the coupons provides a measure of the program's impact. A field study of the intervention was conducted with 75 White and African-American females, all of whom were sexually active. Among prior purchasers of condoms, girls who took part in the intervention were significantly more likely to redeem the coupons than were control groups of their peers. Overall, 60% of program participants obtained condoms, a rate 2 1/2 times greater than that recorded in a comparable program without a confidential coupon redemption procedure.

Focus	☐ Primary pregnancy prevention	☐ Secondary pregnancy prevention	☑ STD/HIV/AIDS prevention
Original Site	☐ School-based	☐ Community-based	☑ Clinic-based

Suitable for Use In

This program can be implemented in a variety of medical or reproductive health clinic settings, providing that arrangements can be made with a local pharmacy for confidential coupon redemption

Approach

- ☐ Abstinence
- ☑ Behavioral Skills Development
- ☐ Community Outreach
- ☑ Contraceptive Access
- ☑ Contraceptive Education

☐ Life Option Enhancement
☑ Self-Efficacy/Self-Esteem
☐ Sexuality/HIV/STD Education

Original Intervention Sample	Age, Gender	The original sample included 75 females, ages 13 to 21 years.
	Race/ Ethnicity	52% African-American, 48% White

Program Components

☐ Adult Involvement
☐ Case Management
☐ Group Discussion
☑ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☐ Role Play
☑ Video
☑ Other Coupons for confidential condom redemption

Program Length

The single, one hour session includes a lecture and video presentation, along with distribution of an educational booklet and coupons for confidential condom redemption.

Staffing Requirement/ Training

A medical or health services professional should lead the educational sessions with groups of up to four teens.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

In 1986, the US Surgeon General issued a report emphasizing that health education could help control the HIV/AIDS epidemic by promoting changes in individual behavior. Drawing upon that report, *A Clinic-Based AIDS Education Program for Female Adolescents* is designed to promote the use of condoms by sexually active girls between 13 and 21 years of age. The brief, single-session intervention combines a lecture covering transmission and prevention of HIV/AIDS with a humorous video demonstrating the purpose and use of condoms for STD protection. Finally, participants receive an educational booklet reinforcing the program messages, along with a coupon that may be redeemed anonymously for a box of condoms.

A field study of the program was conducted in a medical clinic in Little Rock, Arkansas. Participants included 75 sexually active females visiting the clinic for primary health care. Financial support for the study was provided by the Arkansas Department of Public Health.

Theoretical Framework

Studies show that about three quarters of middle and high school students want to increase their knowledge of AIDS In addition, most students would prefer receiving this information from a doctor or nurse, and verbally rather than in printed form. At the same time, when the program was developed, most school-based HIV education programs focused exclusively on providing teens with biomedical information, rather than on encouraging the development of preventive behaviors. The original program developer asserted that HIV/AIDS education could be provided in clinics without the need for the kind of broad-based community support required to launch school-based programs. A medical clinic serving adolescent patients was chosen as a potentially effective site for educating sexually active females about HIV infection and preventive behaviors.

Program Objectives

As an HIV/AIDS risk reduction program, *the Clinic-Based AIDS Education Program for Female Adolescents* is designed to meet the following educational objectives:

(1) to increase female adolescents' understanding of transmission and prevention of HIV/AIDS;

(2) to improve female adolescents' attitudes toward condoms as a method of STD protection; and

(3) to promote the use of condoms by sexually active females.

Program Schedule

The educational intervention is designed to fit into a single, one-hour clinic visit. In the field study of the program, the session was delivered to small groups of teens, ranging in size from one to four participants.

Description of Session Components

Part I: AIDS Education

The session begins with a brief lecture about HIV/AIDS, based on health education guidelines issued by the Centers for Disease Control and Prevention. In particular, the guidelines emphasize that AIDS is a very difficult disease to contract, and that the risk of becoming infected can be virtually eliminated by not engaging in sexual activities or using intravenous drugs.

PART II: Video Presentation

When the lecture concludes, the teens view a 25-minute video, Condom Sense. The video uses humor to explain the purpose and correct use of condoms.

PART III: Wrap-Up

At the conclusion of the session, participants are given a small educational pamphlet to take with them: *What Everyone Should Know about AIDS*. The pamphlet reinforces basic principles about HIV/AIDS transmission, treatment and prevention in simple, easy-to-understand language. In the field study of the program, teens also received a coupon that they could redeem confidentially at the hospital pharmacy for a box of condoms. The coupons were also used in conjunction with the evaluation of the program.

Program Materials: Replicating *Clinic-Based AIDS Education Program for Female Adolescents*

The *Clinic-Based AIDS Education Program for Female Adolescents* program package can be obtained from the Program Archive on

Sexuality, Health & Adolescence. See the Order Form at the back of the book. The package includes the following materials needed to implement this program in your clinic. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Curriculum Materials

Guidelines for Effective School Health Education to Prevent the Spread of AIDS. Originally published by the US Department of Health and Human Services, this booklet reviews the purpose of effective AIDS education and the recommended, age-appropriate content for students. Also included is an outline of the standardized script used in the field study of the program. Together, these materials can help guide your lecture on HIV/AIDS.

Condom Sense videotape. This 25-minute video uses humor to explain the purpose and correct use of condoms. It is shown to participants following the HIV lecture.

What Everyone Should Know about AIDS. This 15-page booklet reinforces basic principles about HIV infection, transmission and prevention. In the field study of the program, it was given to all participants as the session concluded.

Additional Materials

The PASHA program package provides everything needed to implement the *Clinic-Based AIDS Education Program for Female Adolescents*, except for a TV and VCR, which should be available in your clinic or community. Additionally, you will need to produce coupons that teens may redeem confidentially for condoms.

How to Implement the Program

A Clinic-Based AIDS Education Program for Female Adolescents should be led by health professionals who are knowledgeable about HIV/AIDS and risk behaviors, particularly as they pertain to adolescents. The leaders should also be comfortable discussing sexuality and contraception with teens. Finally, it is important that staff thoroughly review all program materials prior to the start of the session.

Consider Local Needs and Values

The *Guidelines for Effective School Health Education to Prevent the Spread of AIDS* provide information appropriate for students at each of three grade levels: early elementary school, late elementary/middle school and junior high/senior high school. However, the *Guidelines* also note that values vary across communities, so the appropriate grades at which to discuss HIV infection and sexuality must be determined locally, on a program-by-program basis. Because *A Clinic-Based AIDS Education Program* *for Female Adolescents* is aimed at teens who have already become sexually active and is provided in a clinical setting, one might expect to find less variance among participants than in broader school or community settings. However, it is still important that your staff consider which information would be appropriate for your teens and your community.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of *A Clinic-Based AIDS Education Program for Female Adolescents* was investigated in a field study conducted with 75 sexually active females attending medical clinics at Arkansas Children's Hospital in Little Rock, Arkansas. The study compared teens who were randomly assigned to take part in one of three interventions: (1) the control group, who received only an educational pamphlet about HIV/AIDS; (2) the education group, who received the pamphlet, along with a brief lecture on HIV/AIDS; and (3) the enhanced education group (i.e., program participants) who received the pamphlet and lecture, and viewed a video explaining the purpose and use of condoms for STD protection. Additionally, at the conclusion of all three interventions, each teen received a coupon that could be redeemed, confidentially, for a box of condoms at the hospital pharmacy.

Two sets of measures were included in the evaluation. At Time 1, after the interventions concluded, the researchers compared the three groups' HIV/AIDS-related knowledge and attitudes, as well as their use of condoms. At Time 2, the condom redemption rate for each group of teens was used as a measure of the program's effect on behavior.

Evaluation Questions

The researchers hypothesized that program participants (i.e., those assigned to the enhanced education group) would show the most positive outcomes, as compared to their peers in the other two groups. In particular, program participants were expected to show:

(1) greater gains in their HIV-related knowledge;

(2) greater improvement in their HIV-related attitudes; and

(3) higher rates of confidential condom redemption using the program coupons.

Data Collection Procedures

The researchers recruited teens who sought routine medical care at Arkansas Children's Hospital. They explained the purpose of the study, obtained written informed consent, and randomly assigned the teens to one of the three conditions: control (N=25), education (N=25) or enhanced education (N=25). Professional medical staff then carried out the appropriate intervention with small groups of youth, ranging in size from one to four participants.

Adolescents in the control (i.e., pamphlet-only) group were first asked whether they had questions about AIDS. Staff addressed any questions, distributed the educational booklets and condom coupons, and then administered all Time 1 measures. A similar procedure was followed with the education and enhanced education groups. That is, Time 1 measures were taken after the educational activities concluded and participants had received the confidential condom coupons.

Although no names were written on the coupons, each was marked with an identification number, and the researchers privately recorded the identification number printed on the coupon each teen received. To calculate the Time 2 (follow-up) measures, the researchers matched the ID numbers to the teens recorded in their roster.

Research Sample

The researchers recruited 82 teens for the study, of whom 77 agreed to participate. Of this group, 36 were White and 41 were African-American. Because two teens failed to provide complete data for the study. the final sample included 75 adolescent females. All described themselves as sexually active and had a history of sexual activity in their medical records.

Evaluation Results

On the Time 1 measures, taken immediately following the interventions, the researchers found no significant differences among the three groups on background measures (e.g., age, race, insurance status), previous condom purchases, or personal experience practicing HIV/AIDS preventive behaviors.

AIDS-Related Knowledge

The evaluators found that none of the teens in the control group asked any questions about AIDS when prompted to do so, and this group scored significantly lower than the two groups receiving the brief HIV/AIDS education lecture (p<.001). However, the two education groups did not differ in their knowledge scores.

AIDS-Related Attitudes

Following the interventions, the three groups showed no significant differences in their attitudes toward people with AIDS, their feelings toward preventive behaviors, or their beliefs about the severity of the disease.

Condom Redemption

The researchers found that 60% of program participants (i.e., the enhanced education group) redeemed their coupons for condoms at the hospital pharmacy, while 44% of the education group and 48% of controls did so. This difference was not statistically significant. However, when the researches focused on the subset of teens who had previously purchased condoms, program participants showed significantly better outcomes. In particular, among sexually active females who had purchased before the intervention began, program participants were significantly more likely than their peers in the two other groups to obtain condoms at the hospital pharmacy (p<.05).

Summary

The results of the evaluation suggest that a brief, single-session intervention can motivate sexually active females who have previously obtained condoms to do so again. The 60% condom redemption rate for the enhanced education group was not significantly higher than that of the other two groups; however, it was nearly two and a half times greater than that recorded (25%) in a previous study lacking a confidential redemption procedure. The evaluators also noted that the intervention—consisting of a brief lecture, video and provision of an educational pamphlet and condom coupon—proved fast, easy to implement and inexpensive. Moreover, because the program is designed for use in a medical clinic, it may reach high-risk teens who do not regularly attend school.

In interpreting the data, the researchers noted that the enhanced education (i.e., lecture + video) treatment appeared to be no more effective than the education (i.e., lecture) treatment alone. However, the small number of teens in each group reduced the statistical power of tests for significant outcomes. Additionally, though the two education groups showed greater understanding of HIV/AIDS relative to their control group peers, the data must be viewed cautiously. In the absence of longer-term follow-up measures, it is not possible to determine whether the differences resulted from exposure to the intervention.

Evaluation Materials for *A Clinic-Based AIDS Education Program for Female Adolescents*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments*, the *Prevention Minimum Evaluation Data Set (PMEDS)* and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

Included in the *Original Evaluation Instruments* are four questionnaires used in the field study of the program. All were used at the Time 1 assessment, immediately following the conclusion of the intervention.

AIDS Knowledge Assessment Questionnaire-Revised. This 52-item survey probes teens' understanding of HIV infection, transmission, diagnosis and treatment.

AIDS Attitudes Survey. The 26 items on this survey assess teens' views about engaging in preventive behaviors, feelings towards people with AIDS and evaluation of the threat posed by the disease.

Background Measures. This 23-item instrument includes sociodemographic measures, as well as questions asking participants to rate the difficulty and appeal of each program component.

Condom Scale. This 10-item scale, developed by the program evaluators, measures the frequency with which teens have purchased, discussed and used condoms during the previous six months.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *A Clinic-Based AIDS Education Program for Female Adolescents*. It is designed self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the *PMEDS* questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants of teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

18

Get Real about AIDS®

An Adolescent STD/HIV/AIDS Prevention Program

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Bibliography

Main, D. S., Iverson, D. C., McGloin, J., Banspach, S. W., Collins, J. L, Rugg, D. L., & Kolbe, L. J. (1994). Preventing HIV infection among adolescents: Evaluation of a school-based education program. *Preventive Medicine*, 23(4), 409-17.

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Program Abstract

Title **Get Real about AIDS®**

Summary

This fourteen-session program for high school students emphasizes behavioral skill development. During the first several classes, students study transmission and prevention of HIV, teen vulnerability to the virus, and determinants of risky behaviors. In the second half of the program, students learn and repeatedly practice skills to help them identify, manage, avoid, and leave risky situations. The lessons encourage students to delay having sexual intercourse, be monogamous, avoid drugs and alcohol when they do have intercourse, use condoms correctly, get tested for HIV infection if they are at risk, and avoid sharing needles.

A field study of the curriculum was conducted in seventeen Colorado high schools serving rural, suburban, and urban populations. In a six month follow-up assessment comparing *Get Real about AIDS®* participants with a comparison group of peers, sexually active program participants had fewer sexual partners, purchased and used condoms more frequently, intended to engage in sex less frequently and planned to use condoms when they did. The evaluation data did not record, however, a delay in the onset of sexual activity, a decrease, the frequency of sexual activity or a reduction in drug and alcohol use prior to sex.

Focus

☐ Primary pregnancy prevention
☐ Secondary pregnancy prevention
☑ STD/HIV/AIDS prevention

Original Site

☑ School-based
☐ Community-based
☐ Clinic-based

Suitable for Use In

Although it was originally implemented in high school classrooms, this program is equally suitable for use in community-based organizations.

Approach

☑ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach

- ☐ Contraceptive Access
- ☑ Contraceptive Education
- ☐ Life Option Enhancement
- ☑ Self-Efficacy/Self-Esteem
- ☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age	A total of 2,849 teens participated in the field study; the average age was 15 years.
Gender	51% Male
Race/ Ethnicity	65% White, 21% Latino, 6% African-American, 3% Asian, 5% Other

Program Components

- ☐ Adult Involvement
- ☐ Case Management
- ☑ Group Discussion
- ☑ Lectures
- ☐ Peer Counseling/Instruction
- ☑ Public Service Announcements
- ☑ Role Play
- ☑ Video
- ☐ Other __________

Program Length

The program is divided into fourteen class sessions, each 50 minutes in length; the sessions can be scheduled to suit your own needs.

Staffing Requirement/ Training

The program is led by regular classroom teachers, preferably in health or science classes. In the field study, special training was provided to instructors in a five-day, 40-hour session designed to enhance fidelity to the curriculum. Videotaping and critiques of practice lessons were also included.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

The Comprehensive Health Education Foundation (CHEF) originally published this STD/HIV/AIDS prevention curriculum in 1988, using the title *Here's Looking at AIDS and You™.* Following field testing and evaluation of the materials, *Get Real about AIDS®* was introduced as the revised curriculum. The fourteen-session curriculum is designed to educate teens about their vulnerability to HIV/AIDS and teach them the skills necessary to reduce their risk of infection. Separate editions are available for upper elementary, junior high and senior high school students; it is the high school edition that is included in your PASHA program package.

During the first five sessions, participants learn basic facts about transmission and prevention of HIV, including behaviors that would put them at risk of infection. During sessions six through twelve, students learn how to set limits around risky behaviors. The final sessions help students integrate what they have learned in the program into their own lives. The program encourages teens to delay having intercourse, or for those youth who do become sexually active, to be sexually monogamous, avoid drugs and alcohol that could cloud one's judgment during intercourse, use condoms, get tested for HIV if they believe they are at risk, and avoid sharing needles.

Get Real about AIDS® (2nd edition, grades 9-12) was field tested in ten high schools throughout Colorado. Funding for the study was provided by a contract to the Colorado Department of Education from the Division of School and Adolescent Health of the Centers for Disease Control and Prevention.

Theoretical Framework

According to the original evaluators, the program's organization and content can be viewed within two theories for promoting health-related behaviors in youth: **Social Cognitive Theory** and the **Theory of Reasoned Action.** Although they use different terminology, both theories assert that knowledge alone is insufficient to produce behavioral change. Rather, four factors together determine the likelihood of engaging in some action, such as using condoms to protect oneself from HIV/AIDS:

(1) a person's understanding of what must be done to avoid infection;

(2) the belief that one will be able to use condoms;

(3) the belief that the method will be successful in preventing infection; and

(4) the benefit one anticipates from accomplishing the behavior (e.g., staying healthy).

The curriculum is divided into three components: information, skills and vulnerability and personal impact. The informational component is designed to help teens understand and avoid sexual risk behaviors. Skills training provides instruction and repeated practice in setting and sticking to limits. The final component is designed to help participants understand their own vulnerability to HIV infection, as well as the personal impact of AIDS on their lives.

Key Messages in the Curriculum

Six ideas are reinforced throughout the program sessions.

- AIDS is a serious disease, but it is not easy to get.
- For young people, abstinence from sex and from drugs is the only sure way to prevent becoming infected with HIV.
- Young people have the ability to avoid situations that place them at risk of becoming infected with HIV.
- Young people have the right to have their limits respected.
- Young people have the responsibility to educate others about AIDS.
- People with AIDS deserve our understanding and support.

Program Objectives

Get Real about AIDS® aims to reduce students' risk of HIV/AIDS and other STDs. Specifically, the curriculum is designed to achieve the following objectives:

(1) increase students' knowledge of STDs and HIV/AIDS;

(2) increase students' awareness of their vulnerability to infection;

(3) delay the onset of sexual intercourse among students;

(4) increase safer-sex behaviors among sexually active students, including:

—maintenance of monogamous relationships,

—abstinence from drugs and alcohol before intercourse,

—consistent and correct use of condoms,

—getting tested for HIV infection if one is at risk; and

(5) increase students' awareness of the risks associated with sharing IV drug needles.

Program Schedule

Program Overview

A brief overview of the content and learning objectives for all fourteen program lessons appears below. In addition, instructors will find comprehensive lessons plans in the *Get Real About AIDS® Teacher's Guide*. This guide includes masters for all information sheets and handouts needed to implement the program. Each lesson is designed to last approximately 50-60 minutes, though the length will vary with the extent of class discussion.

Program Outline

LESSON 1: Teenage Vulnerability to HIV

This introductory lesson is designed to establish a comfortable environment for learning about AIDS. At the start of the session, the instructor presents the program's methods and goals, discusses HIV/AIDS and teen vulnerability to infection, and establishes ground rules for the program. A video and group discussion are used to explore the myth that teenagers do not get AIDS. Participants are invited to submit questions to the Question Box. They may put their questions in this box any time throughout the course, and they should be given class time to write questions every few sessions. At the end of the period, students are given a newsletter to take home to their parents. The newsletter provides suggestions for parent-child communication regarding HIV/AIDS.

LESSON 2: The Transmission of HIV

In this lesson, teens participate in a simulation that is designed to demonstrate the spread of the AIDS epidemic; they also learn how to assess their own risk of HIV infection. The session concludes with a discussion of HIV testing, including laws about confidentiality.

LESSON 3: All about AIDS and Other STDs

Additional information is provided in this lesson about the ways teens can and cannot become infected with HIV and other STDs. Students view the video *The Subject is HIV*, which emphasizes two primary messages: (1) AIDS is hard to get, and (2) You can get AIDS by shooting up or having sex with someone who is infected. Cooperative learning teams are organized to study various STDs using the *STD Facts* pamphlet included in the program package, and these teams will continue to work together for the remainder of the program. Finally, the instructor asks participants to interview friends and family members about their knowledge of HIV, and to share what they have learned in class with these people.

LESSON 4: Delaying Sex

This lesson provides students with reasons for delaying sexual activity; then, working in small groups, participants consider the ways, both positive and negative, in which relationships change when they become sexual. The instructor asks how the positive changes could be realized without sex. For homework, students are instructed to ask two or three adults how people know whether they are ready to have sex.

Note: This lesson was not included in the original field study of *Get Real about AIDS®*; it was added later by the program developers.

LESSON 5: Preventing HIV Infection

This lesson teaches students about the importance of correct and consistent condom use. The instructor first notes that the only sure way to avoid AIDS and other STDs is to abstain from sex and IV drug use. However, since some teens are sexually active and most others will be active eventually, the instructor describes condoms as an effective means of preventing transmission. After describing the procedures for correct use, the instructor demonstrates with a penile model. The class considers reasons why many teens fail to use condoms and explores the concepts of responsibility and personal protection. For homework, students are asked to visit a store that sells condoms and complete a "Point of Purchase" data form.

LESSON 6: Limits

The instructor begins this lesson by discussing limits teens encounter in everyday life (e.g., driving a car requires a license, holding a job requires getting to work on time). Students then consider the limits which will keep them safe from HIV transmission, and explore reasons why it is important to set limits before you encounter a risky situation. The barriers which might keep people from sticking to their limits, as well as the consequences, of not sticking to limits are also discussed. Students then participate in a small group exercise in which they think of ways to help someone stick to their limits. When finished, the groups share their ideas with the class. Finally, the class develops a list of limits and consequences concerning sexual behavior; this list is used during the following few lessons.

LESSONS 7 AND 8: The Refusal Skill™, Days 1 and 2

These two classes introduce The Refusal Skill™, which helps students stick to their limits in risky situations. It is recommended that students be videotaped during skill practice, if possible, so that they can receive more specific, in-depth feedback. In addition, it is also suggested that the instructor have an assistant model the skill, observe role plays, and offer feedback to students. During the first part of the lesson, students view segments of the *Stick to Your Limits* video, and discuss how successful the characters were in maintaining their limits. Then they learn about and practice The Refusal Skill™, using examples from the list of limits students developed in Lesson 6. During the second half of the lesson, students continue to practice the skill and explore their feelings in the process.

LESSON 9: Peer Messages

In this lesson students examine different ways of giving messages about HIV/AIDS to others. They watch the *Public Service Announcements* video and discuss the advantages and disadvantages of receiving information in this format. A worksheet prompts students to consider what messages about HIV/AIDS they would like to share with others. Students discuss their responses in small groups, sharing their results with the class when finished. Finally, the instructor encourages students to help spread the word about HIV/AIDS to their friends and family.

LESSON 10: Using The Refusal Skill™ Proactively

In this lesson, students apply The Refusal Skill™ to avoid getting into risky situations. Students view and discuss segments of the *Stick to Your Limits* videotape and then participate in related role play exercises. The instructor teaches students special techniques to use when they feel pressured to enter into risky situations.

LESSON 11: Becoming Comfortable Using The Refusal Skill™

To help students become more comfortable avoiding risky situations, this lesson includes additional role play exercises. These exercises can also be videotaped to provide participants with in-depth feedback. In conjunction with the activities, the class discusses obstacles to using the skill and ways to overcome them.

LESSON 12: The Refusal Skill for Self-Control™

Students learn a modified version of The Refusal Skill™ that is designed to help them say "No." Using segments from the *Stick to Your Limits* video, students discuss how individuals can stick to their limits, avoid risky situations and still have fun. These ideas are reinforced with practice exercises. In addition, the instructor encourages students to think about their own limits and the kinds of situations where they might apply the skills they have learned.

LESSON 13: The Community Meeting

This lesson, built around a large-group role play, requires at least 20 participants. Students act out the parts of community members who meet to talk about a high school student, Charles Crawford, who has contracted HIV. Students are assigned to roles (e.g., the principal, school board members, students, the school nurse) and given diverse points of view to represent (e.g., people with HIV are dangerous; people with HIV must be homosexual or use drugs; casual contact with HIV infected people is not a problem). Certain characters fear that Charles is a danger to other students and should be removed from school, while others try to dispel misinformation about HIV/AIDS. After the role play, students discuss their feelings about the exercise, and the instructor asks them to identify incorrect information they heard during the activity. Finally, students are reminded that it is illegal to discriminate against people who are HIV positive. For homework, students are asked to research the policy on employees with HIV at one business in their community.

Note: This lesson was not included in the original field study; it was added later by the program developers.

LESSON 14: Transfer

During the final lesson of the program, students practice using the knowledge and skills they have acquired. Using "The Next Time..." worksheet, students relate skills they have learned in the class to their everyday lives. Then they develop and participate in role plays applying The Refusal Skill™ and The Refusal Skill for Self Control™. To bring closure to the lessons, the instructor reinforces the messages that: (1) HIV/AIDS is hard to get; (2) You can get AIDS by having sex or sharing needles; (3) Abstinence from sex and drugs is the only sure way to avoid AIDS and other STDs; and (4) If teens do choose to have sex, they should use latex condoms. Following this review, the instructor asks students to think about what they have learned from the program, and what they will do differently now that it is over. Students may share their answers with the class if they wish.

Program Materials: Replicating or Adapting *Get Real about AIDS®*

The *Get Real about AIDS®* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of the book. The package includes the following materials needed to implement this program in your school or community-based organization. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Contents and Parts Lists

Get Real about AIDS® Grades 9-12 Kit Contents List (2nd Edition) and *Get Real about AIDS® Grades 9-12 Kit Parts List*. These two pages list all materials included in the program package. The first list is organized by program session, and the second by type of item (e.g., poster, video).

Teacher's Guide

Get Real about AIDS® Teacher's Guide, High School Edition (also referred to as the *Teacher's Guide).* This guide contains comprehensive lesson plans for all fourteen program sessions. It also includes background information on the goals and methods of the program, and masters for all fact sheets and homework activities.

Posters

Only Homosexuals Get AIDS, myth/fact poster. This poster is used for a discussion of myths about HIV/AIDS during Lesson 2.

Only White People Get AIDS, myth/fact poster. This poster is also used for a discussion of myths about HIV/AIDS during Lesson 2.

People Who Are In Good Health Don't Get AIDS, myth/fact poster. This poster is used during Lesson 2 to help students understand transmission and prevention of HIV.

Teenagers Don't Get AIDS, myth/fact poster. This poster is part of the discussion of myths about HIV/AIDS that takes place during Lesson 2.

You Can Catch AIDS From Being Near Someone Who Has AIDS, myth/fact poster. This poster is used for the community meeting exercise that takes place during Lesson 13.

People Who Plan To Use Condoms Are "Loose," myth/fact poster. This poster is used during Lesson 5 for a discussion of barriers to condom use.

It's the Male's Responsibility To Protect..., myth/fact poster. This poster is also used during the Lesson 5 discussion of barriers to condom use.

The Refusal Skill™ steps poster. This poster, used during Lessons 7, 8, 10 and 11, outlines the steps involved is applying the skill.

The Refusal Skill for Self Control™ steps poster. This poster is used to help students learn the skill during Lesson 12.

Ground Rules poster. To help familiarize students with basic rules for maintaining comfort and privacy during group discussions, this poster is used at the start of the first program session.

Watch What You Do: AIDS Can Happen To You message poster. This poster is used to reinforce lessons about HIV transmission during Lesson 2.

Question Box

Question Box. This box should be available to students throughout the program sessions. Students are invited to write down any questions they may have about HIV/AIDS and other STDs; a new group of questions is answered every few sessions.

Videos

Teen AIDS in Focus videotape. Shown during the first program lesson, this 16-minute video describes the lives of five teens who are HIV positive. The tape emphasizes the impact the disease has on the characters' life plans.

The Subject Is: HIV videotape. This 16-minute tape, featuring interviews with people who are HIV-positive and living with AIDS, helps dispel some of the myths about HIV and AIDS. It is shown during Lesson 3. Please note that the film shows people shooting up heroin.

Stick to Your Limits videotape. This 8-minute videotape, shown during Lessons 2, 7, 10 and 12, helps reinforce students' mastery of the Refusal Skill™ and the Refusal Skill for Self-Control™. The video consists of several vignettes in which teens find ways of sticking to their limits and leaving or avoiding risky situations.

Public Service Announcements videotape. A collection of the Center for Disease Control's public service announcements is shown during Lesson 9. The video is used to introduce students to the idea of promoting healthy messages through the media. After watching the tape, students work in small groups to create their own PSAs.

Activity Cards

Transmission cards. This set of 30 cards is used during a simulation of the spread of HIV during Lesson 2. Each card is printed with one of 4 letters (e.g., H, C, A, and U). During the simulation, each student receives one card; students with H cards, for example, depict HIV-positive individuals, while the A's represent people who have chosen to be abstinent.

Community role cards. This set of 30 cards is used in conjunction with the community meeting exercise that takes place during Lesson 13. Each card describes one of the characters present at the meeting, along with their position in the debate (e.g., the School District Superintendent who wants to develop a policy that will not discriminate against people with AIDS; a local physician who wants to stem any misinformation about the disease).

Related Resources

STD Facts pamphlet. This brochure is given to students during Lesson 3. It is used by the cooperative learning teams to teach students about the primary symptoms of the major STDs, including Chlamydia, Genital Warts, Gonorrhea, Hepatitis B, Herpes, HIV, Syphilis and Vaginitis. The information covers symptoms, transmission modes, and the consequences of not treating infection. The pamphlet also discusses ways to protect oneself from transmission, and what to do if infection is suspected.

AIDS: A Guide For Survival. This small booklet is designed for teachers and/or program leaders. It includes information on the HIV virus, the AIDS epidemic, modes of transmission, risk reduction and talking to children about HIV/AIDS. Although it contains some complex scientific information on characteristics of the HIV virus, it is presented in a manner that should be accessible to educators.

Additional Materials

The PASHA program package provides everything needed to implement *Get Real about AIDS®*, except for the following materials, which should be available in your school or community: a TV and VCR, photocopier, paper for students to write on, chalkboard or flip chart and markers, condoms, access to art supplies and media equipment (e.g., videorecorder). In addition, instructors are asked to create a "Help" poster listing the names, addresses, and phone numbers of local agencies offering information and support to people concerned with HIV/AIDS and other STDs. Additional instructions for creating and using the poster are found in the *Teacher's Guide*.

How to Implement the Program

During the original field study, a 5-day, 40-hour training workshop was held prior to the start of the program. Designed to enhance instructors' fidelity to program materials, the training included a review of the curriculum and introduction to each of the class sessions, along with practice modeling skills, giving feedback and using a VCR. You may organize a similar event for your staff using the *Teacher's Guide*, which provides a comprehensive overview to the program. Or you may contact the Comprehensive Health

Education Foundation for assistance in arranging training at your school or community-based organization.

Studying the guide should provide sufficient preparation for instructors who are comfortable and experienced in facilitating group activities and discussions of sexuality. In addition, the program package includes the *AIDS Survival Guide;* this small black book is designed to inform teachers about HIV/AIDS and enable them to answer students' questions about the virus. Instructors should read this book before the first lesson begins.

The "Before You Begin" section of the *Teacher's Guide* describes the philosophy, key messages, and structure of the program. Of particular value is the suggested approach for maintaining students' feelings of comfort and privacy and addressing sensitive issues. Suggestions are also provided for organizing cooperative learning teams for many of the group exercises.

You may want to consider using peers leaders and/or cross-age teachers as instructors for various program components. For example, the social skill lessons can be especially persuasive when an older student models and offers feedback to younger students.

Finally, the curriculum contains many assignments in which students carry information they have learned in the program back into their lives. For this reason, is useful for instructors to encourage parents and teachers who are not currently using the curriculum to learn more about it. Moreover, students will need to practice the skills they have learned both in school and in their day-to-day lives. They will also need to review the skills in class after the program lessons have ended. Teachers can reinforce program lessons by providing information to parents and opportunities for students to practice their skills throughout the year.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the original *Get Real about AIDS®* curriculum was investigated in a field study carried out in 17 Colorado high schools. In ten of the schools, trained instructors implemented an intervention that was based on the *Get Real about AIDS®* curriculum. The other seven schools served as comparison sites.

All participants completed confidential, self-report questionnaires assessing their STD/HIV/AIDS-related knowledge, intentions, and behavior. To assess the impact of the program over time, students' responses were compared across two time periods:

- Time 1: before the start of the intervention (pre-test), and
- Time 2: six months following the intervention (post-test).

Evaluation Questions

The evaluation was designed to assess the program's effect on: (1) the initiation of sexual activity among teens; and (2) among teens who were already sexually active at the start of the program, the frequency of sexual risk behaviors.

Specifically, four questions guided the study.

(1) Did participation in the *Get Real about AIDS®* program increase teens' STD/HIV/AIDS-related knowledge?

(2) Did program participation increase students' intention to engage in safer sexual activities (i.e. be monogamous, use condoms)?

(3) Did students who were abstinent at the start of the program continue to postpone sexual intercourse following the intervention?

(4) Did students who were sexually active at the start of the intervention reduce the frequency of behaviors which put them at risk of exposure to HIV (e.g., sex with multiple partners and failure to use condoms)?

Data Collection Procedures

Schools were recruited for the study from six different districts located in rural, urban, and suburban settings throughout Colorado. Within each district, comparison and intervention schools were matched as closely as possible with respect to the grade, sex, and racial/ethnic distribution of students. For the duration of the study, comparison schools were encouraged not to implement any new HIV education programs; instead, they were asked to continue using their existing curricula. In four of these schools, no formal HIV/AIDS education was offered. Two of the comparison sites, on the other hand, provided minimal HIV/AIDS instruction to students, including such activities as discussion of infectious diseases in Home Economics classes and exposure to sexuality materials.

Before the self-report questionnaires were administered, each school followed its district procedures for obtaining parental consent. The surveys, which took about fifteen to twenty minutes to complete, were given to students at three points: prior to the intervention, two months after the intervention and six months after the intervention. However, only the baseline and six-month follow-up results were included in the original analysis.

In order to assure students' anonymity, participants were told not to write their names or any identifying numbers on the surveys. Instead, students' Time 1 and Time 2 questionnaires were matched using their responses to the demographic questions.

Sample

Of the 2,844 students who completed the baseline survey, 65% were White, 6% were African-American, 21% were Hispanic, 3% were Asian and 5% were classified as "other." Females made up 49% of the initial respondents, males 51%. The average age of participants was 15 years. In addition, 44% of this group indicated that they had engaged in sexual intercourse, 25% of students had been sexually active within two months of the initial survey, and 1.6% had injected drugs.

Matching students' Time 1 and Time 2 surveys yielded a final sample of 979 participants.

Evaluation Results

Get Real about AIDS® appeared to be effective in changing students' knowledge, intentions and some behaviors, but not in postponing the onset of sexual activity or in reducing the use of injectible drugs.

Knowledge

Compared to their peers in the comparison schools, program participants showed significantly greater knowledge of HIV/AIDS at the six month follow-up assessment (p=0.004).

Behavioral Intentions

Program participants also expressed greater intention to engage in safer sexual practices following the intervention. Compared to their comparison group peers, sexually active students were more likely to report their intention to reduce the frequency of intercourse (p=0.017) and to use a condom when they did have sex (p=0.039). However, no changes were found either in the teens' intentions to discuss condoms with their partners or in their thoughts about the need to use condoms.

Beliefs

Six months following the intervention, program participants were more likely than comparison group students to believe that engaging in risky behaviors put one at risk for HIV infection ($p=0.042$).

Behavior

Behavioral change was observed only among those students who were sexually active. Six months following the program, sexually active *Get Real about AIDS®* participants were more likely than their comparison group peers to purchase condoms ($p=0.046$), have fewer sexual partners ($p=0.046$), and use condoms more frequently ($p=0.048$). No differences were found, however, in their frequency of intercourse, or the frequency with which they used drugs and alcohol prior to intercourse.

Summary

The field study showed that the fourteen-session *Get Real about AIDS®* program can be effective in changing students' HIV-related intentions and behaviors that put youth at risk for HIV infection. Six months following the intervention, sexually active program participants had fewer sexual partners, purchased and used condoms more frequently, intended to engage in sex less frequently and planned to use condoms when they did. However, the onset of sexual activity was not affected by the program in any measurable way. Additionally, although no changes were observed in participants' use of IV drugs, the researchers suggested that the numbers of IV drug using students were so small that any effect would be hard to detect.

In interpreting their results, the evaluators cautioned that the students who were included in the final sample (e.g., those teens whose Time 1 and Time 2 surveys could be matched) showed lower HIV risk scores at the Time 1 assessment. Similarly, those students who dropped out of the program or the comparison group appeared to be at higher risk for HIV infection. Consequently, the results of this field study, and the effects of the *Get Real about AIDS®* program, might not hold for higher-risk groups of teens, along with those youth who have dropped out or are frequently absent from school.

Evaluation Materials for *Get Real about AIDS®*

In addition to the program materials described in an earlier section, the PASHA program package includes three resources for evaluation: the questionnaire used in the original evaluation, the *Prevention Minimum Evaluation Data Set (PMEDS)* and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

The questionnaire used in the field study of the program is provided in a packet entitled *Original Evaluation Instruments*. This questionnaire, the Skills for Life Survey, is a 57-item, self-administered instrument with questions assessing teens' past, current, and future sexual behaviors, and their knowledge, attitudes, and beliefs concerning HIV/AIDS. A few background demographic questions are also included. The same instrument can be used for the pre-test and follow-up assessments.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Get Real About AIDS®*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants of teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

19

Poder Latino
A Community AIDS Prevention Program for Inner-City Latino Youth

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Program Abstract

Title

Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth

Summary

This multifaceted community-based intervention targets Latino youth at elevated risk for HIV/AIDS. One goal of the program is to increase awareness of the disease by saturating target neighborhoods with public service announcements broadcasting risk-reduction messages. In addition, the program aims to reduce HIV infection rates by encouraging sexually active teens to use condoms. Project messages are reinforced through ongoing activities conducted by specially-trained peer leaders. These activities include: workshops in schools, community organizations and health centers; group discussions in local residents' homes; presentations at community centers; and door-to-door canvassing. At all activities, condoms are available, along with pamphlets explaining their correct use. In a field study of the intervention in Boston, MA, researchers compared the sexual behavior of teens in the target community with that of teens in a similar community not exposed to the program. At the 18-month follow-up assessment, the program appeared to reduce the number of partners among sexually active females and delay the onset of sexual activity among males who were not sexually active when the program began.

Focus

☐ Primary pregnancy prevention
☐ Secondary pregnancy prevention
☑ STD/HIV/AIDS prevention

Original Site

☐ School-based
☑ Community-based
☐ Clinic-based

Suitable for Use In

Poder Latino was specially designed for an inner-city Latino community. However, the structure and content of the program might be adapted for use with other groups at high risk for HIV infection.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☑ Community Outreach
☑ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☑ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age/ Gender	During the field study, the intervention targeted an entire community; evaluation of the program included 586 youths, who ranged in age from 14 to 20 years.
Race/ Ethnicity	100% Latino, nearly all Puerto Rican

Program Components

☑ Adult Involvement
☐ Case Management
☑ Group Discussion
☑ Lectures
☑ Peer Counseling/Instruction
☑ Public Service Announcements
☑ Role Play
☐ Video
☐ Other _________

Program Length

There is no requisite length for the program; the field study was implemented over an 18-month period.

Staffing Requirement/ Training

Program activities are led by peer leaders who take part in an extensive training program. Staff who lead this training should be knowledgeable about HIV/AIDS, Latino culture and group process skills. Additionally, staff and peer leaders should be able to communicate both in English and Spanish.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

Throughout the United States, Latino neighborhoods show elevated rates of HIV infection. *Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth* is a multi-faceted intervention designed to raise the entire community's awareness of HIV/AIDS and reduce the risk of infection by increasing the use of condoms among sexually active teens.

In 1990, the New England Research Institutes (NERI) launched this community-based intervention in an inner-city Latino neighborhood in Boston, Massachusetts. NERI enlisted a local organization, the Latino Office of Planning and Evaluation (HOPE), to develop the intervention materials. NERI staff, in conjunction with HOPE personnel, began by conducting interviews and focus groups to investigate local residents' opinions, attitudes, beliefs and behaviors related to AIDS. The results of the study helped shape both the structure and content of the program. In particular, *Poder Latino* was designed to: (1) provide explicit, factual information in language that is comprehensible to teens; (2) offer educational activities appealing and relevant to the Latino community; (3) enhance feelings of pride and self-esteem; and (4) empower residents to take healthy action for their own lives and for their community.

During the field study of the program, much of HOPE's efforts focused on recruiting, training and supervising peer educators, who were Latino teens in the target community. The peer educators then took responsibility for educating their community through a variety of activities. To promote *Poder Latino*'s HIV prevention messages, the youth created and displayed posters; wrote teen newsletters; broadcast public service announcements; held community workshops; attended health fairs; and led home-based charlas, or chats. HOPE staff also trained parents to serve as Community Health Educators; the adults, too, held charlas with other adults, as well as with adolescents and adults together.

Funding for the program was provided by the National Institute of Child Health and Human Development.

Theoretical Framework

The lack of research on factors related to HIV transmission in Latino communities required the program developers to use innovative methods to develop appropriate educational strategies. Using ethnographic research methods, they first sought to understand local residents' opinions, attitudes, beliefs and behaviors related to AIDS. An anthropologist from NERI conducted focus groups and interviews with 44 parents, caretakers, adolescents, church leaders, teachers and counselors in the target community. The following principles emerged from these conversations.

(1) The intervention should be community-based.

(2) The intervention should target a broad age range.

(3) The intervention should involve community outreach.

(4) The intervention should be factual and explicit in presenting AIDS information, yet address teens in ways that they can understand.

(5) The intervention should instill in Latino teens a sense of cultural pride and a sense of history.

(6) The intervention should be bilingual.

(7) The intervention should facilitate a sense of empowerment among Latino teens.

(8) The intervention should utilize peer leaders or forums facilitated by teens.

(9) The intervention should seek to involve the parents of adolescents.

Guided by the principles listed above, the program developers engaged local adolescent and adult residents to serve as persuasive and appealing opinion leaders. After completing a training program, the leaders were charged with promoting program messages in a variety of social settings. The training followed a "health circles" approach, patterned after the successful literacy campaigns organized by Paulo Freire in Brazil. In the *Poder Latino* program, trainers and trainees took part in activities that were designed to discover, create and promote the most effective and relevant prevention messages for the target community. The success of this method required that the trainers enter into a continuing dialogue with the trainees so that ownership over the process would be shared; from this process the *Poder Latino* curriculum emerged and evolved.

Program Goals

As an HIV/AIDS prevention program, *Poder Latino* aims to achieve three goals:

(1) to increase awareness of HIV/AIDS by saturating the community with risk-reduction messages;

(2) to reduce HIV infection by encouraging sexually active teens to use condoms; and

(3) to increase communication between parents and teens about sexuality.and HIV/AIDS.

Program Components

Three program components—each encompassing multiple activities— were implemented during the field study of *Poder Latino*. You might follow a similar structure in your own community, or modify components to fit local residents' interests, needs and values.

Peer Educators

Based on the premise that youth can most effectively convince their peers to refrain from risky behaviors, HOPE staff members recruited and trained Latino teens to serve as peer educators/leaders in their local community. Sixteen youth (ages 14-19) were recruited to participate in an intensive program teaching basic information about HIV/AIDS, the importance of practicing safer sex and community resources for diagnosis, testing and treatment. In addition, group exercises were designed to develop and strengthen participants' self-esteem, pride in Latino culture and decision-making skills. To prepare the teens for assuming educational leadership roles in their community, the training also included discussion and repeated practice in conveying health education information to youth.

After completing the training program, the youth were charged with creating and conducting AIDS awareness activities with their peers. To reach adolescents in a wide variety of settings, the peer educators:

- developed posters promoting the use of condoms for HIV prevention and posted them at local businesses and public transit facilities;
- wrote Teen View newsletters and distributed them throughout the neighborhood;
- wrote public service announcements promoting condom use for local radio and television stations;
- conducted workshops in neighborhoods, community centers and schools to talk about HIV/AIDS, sexuality and the importance of using condoms for safe sex;
- staffed booths at health fairs and handed out condom packets;

- canvassed the neighborhood to educate local residents about HIV/AIDS transmission and prevention;
- distributed on street corners, door-to-door and at all program activities kits of condoms and instructions on how to use them; and
- visited residents' homes to conduct a series of charlas (chats) encouraging teens and parents to discuss sexuality.

Parent Training

Parents were recruited and trained to serve as volunteer Community Health Educators. Participating parents learned basic information about HIV/AIDS, as well as techniques to enhance their communications skills. As Community Health Educators, the parents conducted charlas (chats) with other adults and teens in home settings.

Community Advancement Collaboration

HOPE staff members organized a network of seven community-based Latino agencies, called Proyecto Luces. The network was designed to:

(1) encourage collaboration among community-based Latino agencies in shaping and delivering HIV prevention messages;

(2) act as a catalyst and resource, enabling the community to mobilize itself; and

(3) ensure that HIV education and prevention would continue once the field study of *Poder Latino* concluded.

Within the target community, participating agencies helped to organize cultural festivals, health fairs and workshops at which condoms were distributed and AIDS awareness messages promoted. Individual community members also get involved. Latino/Latina artists, for example, designed materials to promote program messages that had originally been developed by the peer educators.

Training Schedule

The primary focus of *Poder Latino* is to train peer educators/leaders, who then create and implement a variety of program activities promoting HIV prevention messages.

Peer Educator Training

During the field study of the program, training sessions were held both during the school year and summer, during which the teens were paid. An overview of the seven-week summer program (with three or four sessions per week, each lasting about three hours) is presented below. Detailed outlines for leading each session are included in the *Peer Educator Training Guide* included in the PASHA program package.

WEEK 1: Introduction to the Program

During the first week of the training program, the leaders strive to build rapport between themselves and the teens. Discussions are designed to clarify roles and expectations for the teens' work as peer educators, particularly the importance of educating others about risky behaviors and how to avoid them. Toward that end, the teens identify situations in which they could pass on prevention messages to their peers. At various points during the sessions, youth are asked to volunteer to facilitate the discussion so that they can begin developing and practicing leadership and communication skills.

WEEK 2: Cultural Identity, Personal Growth and Development

During the second week of the training program, activities are designed to help teens develop pride in Latino culture and better understand the strength and beauty of the diverse nationalities and ethnic origins of Latinos. In one exercise, for example, participants are asked to write their autobiographies, describing how long they (or their parents) have lived in the United States, a typical day in their life and their future aspirations. The disproportionate impact of AIDS on the Latino community is also discussed. Then, as a group, teens are asked to share what they have liked, or found difficult, about growing up as a member of a particular ethnic minority (e.g., Puerto Rican). Finally, the focus shifts to pressures teens face in school, at home and from peers. Role-play exercises are used to help practice resisting peer pressure.

WEEK 3: Building Self-Esteem, Skills in Decision-Making and Conflict Resolution

The first session of the week begins with a group discussion of teens' personal accomplishments. The trainers highlight the importance of self-esteem and striving to reach one's potential. The remainder of the week focuses on the development of decision-making skills, especially as they relate to conflict resolution and HIV prevention. The field study of the program also included a field trip to the Massachusetts State House, during which the teens were introduced to elected officials and invited to share their thoughts and feelings about leadership.

WEEK 4: AIDS 101: Counseling & Testing, and Impact upon Family and Friends

During this set of sessions youth learn basic facts about HIV/AIDS, including transmission, prevention, treatment and testing. Group discussions explore loss and other feelings that a person with AIDS/HIV may experience. The youth also learn a process for assisting someone with the "to test or not to test" decision.

WEEK 5: AIDS and Substance Abuse

Focusing on risky behaviors and their relationship to HIV infection, teens define substance abuse and identify signs and symptoms of abuse among their peers. The first session of the week begins with an icebreaker exercise in which the youth explore their own values and beliefs about drugs and drug abuse. Additional discussion focuses on the impact of the media on teens' perceptions of drugs. The field study of the program also featured a presentation offering a community perspective on substance use and abuse. Finally, the group takes part in a series of role-play exercises to practice resisting pressures to use alcohol and other drugs.

WEEK 6: How to Serve as a Peer Educator/Leader

The final two weeks of the training program prepare teens to serve as HIV prevention peer educators and leaders. The trainers help the youth identify and practice basic communication and self-presentation skills, including listening, facilitating group discussions, open questioning to promote dialogue and assertiveness. The youth also learn problem-solving skills they will need as they begin planning and leading educational activities in their community. To apply these skills, the youth use the third and fourth days of the week to begin working on either a newsletter, contest, or other prevention activity committee. Each committee is asked to create a plan for their first project, including a budget, timeline and outline for promotion, recruitment, production and evaluation of their work.

WEEK 7: Linking with Community Resources and Summary

During the final segment of the training program, the teens spend about four days working with their committees to finalize their project plans. Throughout the sessions, the trainers emphasize the importance of the teens' work and encourage them to involve others in their efforts, including community leaders and representatives from social service agencies. Guest

speakers might be invited to visit the group and offer additional suggestions for community education activities.

OPTIONAL WEEK: Sexual Identity, Healthy Lifestyles and the Risk of Sexually Transmitted Diseases (STDs)

During the original field study, an additional set of sessions was designed to improve teens' understanding of sexual orientation, sexual identity and STDs. The group learned basic facts about puberty, reproductive development and the impact of teen pregnancy/parenting on adolescents' lives. The trainers emphasized the benefits of delaying pregnancy until one is emotionally ready to meet the challenges. Treatment and prevention of STDs were also discussed. You may want to organize a similar set of sessions for your intervention.

Parent Training

The *Poder Latino* program developers also created a two-session training curriculum to provide Latino parents and community members with basic information about HIV as it pertains to the Latino community. The curriculum encourages the development of communication skills needed to serve as a Community Health Educator.

The parent training program, as outlined in the *Parent Training Guide,* contains three modules or units:

(1) HIV Disease—The Facts;

(2) Listening and Communications Skills; and

(3) Home-Based Education Sessions.

In the field study of the program, the training was delivered over a two day period, with three to three and a half hour sessions offered each day, as described below.

DAY 1: HIV Disease—The Facts

The first training session provides adults with basic information about AIDS: what causes AIDS; how HIV differs from other viruses; how HIV is transmitted; and how it can be prevented. During the original field study, adults were also asked to complete a short, twenty-item test of their understanding of HIV/AIDS.

DAY 2: Listening and Communication Skills and Home-Based Education Sessions

The second day of the program is designed to enhance participants' confidence, knowledge and skills in presenting AIDS risk-reduction messages as they pertain to the Latino community. The participants complete a series of exercises to practice their listening and communication skills. The trainers then distribute a copy of the *Poder Latino Home-Based Education Sessions Manual* and *HIV Disease—Basic Facts Presentation Packet* to each adult and discuss the concepts and objectives of the home-based sessions.

Program Materials: Replicating or Adapting *Poder Latino*

The *Poder Latino* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence. See the Order Form at the back of the book. The program package includes the following materials needed to implement *Poder Latino* in your community. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package. During the field study, all materials were printed both in English and Spanish.

Training Materials

The Peer Educator Training Guide includes detailed lesson plans and related information for implementing each session of the seven week program for youth. For each session, the goals, objectives, agenda, activities and estimated time are included.

Cinquenta Preguntas y Respuestas Sobre el SIDA/Fifty Questions and Answers on AIDS. This booklet was distributed as a resource for teens and parents to use in their work as health educators. Included are key facts about transmission, symptoms, treatment and prevention of HIV/AIDS.

The *Parent Training Guide* provides the complete curriculum for preparing parents to serve as Community Health Educators.

Poder Latino Home-Based Education Sessions Manual. This manual should be given to all parents during the second day of the parent training program. It is designed to guide adults in leading home-based education sessions with community residents. Included are step-by-step instructions for leading each activity, estimated times for each exercise, fact sheets and blank forms to list the names of attendees and provide feedback on the session. Also included in your program package is the Spanish edition, *Manual para Sesiónes de Educación en el Hogar.*

HIV Disease—Basic Facts Presentation Packet. In the field study of *Poder Latino*, project staff prepared this packet to assist parents in conveying basic information about HIV/AIDS during the home-based education sessions. The material is displayed in annotated outline form, ready for presentation.

Sample Activity Materials

Charlas. In the PASHA program package you will find outlines for three charlas, or in-home chats, that were used during the original field study of *Poder Latino*. Your peer educators may want to use or adapt these materials when visiting homes to engage teens and parents in talks about sexuality and HIV/AIDS. Each booklet contains bilingual scripts and tips on listening.

- *Charla #1: How AIDS affects our lives in the community and our family life*
- *Charla #2: What I know and feel about AIDS*
- *Charla #3: AIDS—What is it and why?*

The following materials were developed by the program developers and peer educators for the field study of *Poder Latino* in Boston. You may want to copy elements of these items or develop your own materials.

- *Public Service Announcement Scripts.* These educational announcements were broadcast on local television and radio stations.
- *Posters.* To promote the use of condoms, these posters were displayed throughout the community.
- *Teen View Newsletters.* The peer educators developed and produced these bilingual newsletters with assistance from HOPE staff. The articles informed local teens about project activities and reinforced HIV prevention messages.
- *Para La Salud Flyers.* These one-page flyers were used to update local teens about the project. Each mailing contained a stamped postcard on which the teens were asked to write their address and telephone number, even if they had not moved. In this way the researchers were able to keep track of the teens taking part in their evaluation of the program.
- *Parent Recruitment Form.* HOPE staff members developed this brief survey to screen parents who were interested in participating in the parent training program.

Additional Materials

The PASHA program package provides everything you need to implement *Poder Latino*, except for the following materials, which should be available in your community: chalkboard or flip chart and markers, pencils and index cards. Condoms will also be needed for demonstration and distribution at all program activities.

How to Implement the Program

Your implementation of *Poder Latino* will benefit greatly from active support and participation across all segments of the community, including community-based organizations, church representatives, teachers and educational administrators, civic leaders, parents and especially, teenagers. Moreover, it is helpful to begin building support for your work before the peer and parent training programs begin. During the field study of the program, for example, the ethnographic research was used as an opportunity to introduce residents to the goals and objectives of the program. Project staff wrote and distributed an open letter describing their work and requesting residents' participation in the focus groups and interviews. Local organizations and community leaders proved helpful in identifying and recruiting teens and adults to participate in the training programs. Following the training, they invited the peer educators to lead sessions at local events and activities.

It is essential that program staff review all of the training guides and manuals included in the program package. The sample activity materials may provide a helpful starting point as educators begin generating their own ideas. Feel free to adapt the *Poder Latino* materials to meet your target community's needs and values.

Evaluating the Program

The Original Evaluation

Design

The New England Research Institutes (NERI) evaluated a field study of *Poder Latino: A Community AIDS Prevention Program for Inner-*

City Latino Youth conducted in Boston, Massachusetts, between June, 1990 and December, 1991. The researchers compared Latino youth in the intervention city (Boston) with their peers in a comparison city (Hartford, Connecticut) on measures of AIDS-related knowledge and attitudes, as well as patterns of sexual activity. To measure the impact of the program over time, interviews were conducted with teens at two points:

- Time 1: before the start of the program (baseline); and
- Time 2: following the conclusion of the program (follow-up).

Evaluation Questions

Opponents of condom distribution to teens have asserted that promoting the use of condoms can encourage increased sexual activity and promiscuity. NERI's study was designed to test those assertions—and assess the effectiveness of the *Poder Latino* program. To that end, the evaluators addressed three questions.

(1) Were adolescents who had not initiated sexual activity prior to the start of *Poder Latino* more likely to become sexually active as a result of the intervention?

(2) Were adolescents who were sexually active at the end of *Poder Latino* more likely to have had multiple partners as a result of the intervention?

(3) Were adolescents who were sexually active at the end of *Poder Latino* having sex more frequently as a result of the intervention?

Data Collection Procedures

Because the program was designed to reach the entire adolescent population in the target neighborhood of Boston, the researchers gathered data from representative community samples, rather than groups of students or teens who actually participated in program activities. The researchers first identified census blocks in Boston in which at least 20% of the population was of Spanish origin. They then used standard block sampling and household enumeration procedures to identify eligible Latino adolescents in these target neighborhoods.

Following the same sampling procedures, the researchers constructed the comparison group of teens in Hartford, Connecticut. Hartford was chosen as the comparison community because its Latino population is similar, in many ways, to that of Boston. At the same time, the researchers reasoned that the 100 mile distance between the two cities would make it difficult for the intervention activities to spill over into the comparison population.

Trained, bilingual staff conducted the two sets of interviews with teens. Within each city, interviewers were paired with participants of the same sex. The interviews, which were held in private places to protect teens' confidentiality, included sociodemographic questions, along with items about AIDS-related knowledge and attitudes and patterns of sexual activity and condom use. To minimize any potential biases among respondents, a separate project title and research team were used throughout the evaluation. In addition, the survey was presented as an investigation of adolescent health, rather than HIV/AIDS.

To minimize attrition over the 18-month study period, the researchers re-contacted participants at three month intervals. They distributed a one-page flyer, *Para La Salud*, that was designed, in part, to update teens about project activities. Included in the mailing was a stamped postcard on which the teens were requested to write their address and phone number, even if they had not moved.

Research Sample

Baseline interviews were completed with 586 Latino adolescents, who ranged in age from 14 to 20. Of this group, nearly all (94%) were Puerto Rican. At the Time 2 assessment, interviews were completed with 536 adolescents, yielding a follow-up rate of 91%. The attrition rate was 7.2% in Boston, the intervention city, and 9.3% in Hartford, the comparison city.

Evaluation Results

Initiation of Sexual Activity

To measure the impact of the program on the initiation of sexual activity, the researchers focused on the subset of teens who had not yet become sexually active when the intervention began. At the Time 1 assessment, nearly half of the adolescents (47.8%) had not had intercourse, and of this group, 227 (88.7%) provided complete data for all of the interview questions.

After statistically adjusting for baseline differences between the treatment and comparison groups, the evaluators found that males in the intervention community were less likely to become sexually active than were their peers in the comparison community ($p<.012$). For females, the intervention neither increased nor decreased their chances of becoming sexually active ($p=.692$).

Number of Sexual Partners

To measure the impact of the program on the number of sexual partners, the researchers looked at the group of teens who were sexually active at the follow-up assessment period. In the Time 2 interviews, 433 respondents (80.8%) reported sexual activity, and

403 teens (93.1%) provided complete data. Again, statistical methods were used to control for baseline differences between the two groups of youth.

For female adolescents in the target community, the intervention appeared to reduce the incidence of multiple sexual partners ($p<.006$). There was no corresponding effect for males, who neither increased nor decreased their number of partners ($p=.790$).

Frequency of Sexual Activity

Focusing again on the subset of teens who were sexually active at Time 2, the researchers found that *Poder Latino* had no impact on the frequency of sexual activity among either males or females.

Summary

Evaluation of *Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth* showed that the intervention delayed the onset of males' sexual activity and reduced the number of sex partners among females. Both of these effects are valuable HIV risk reduction outcomes. Together, this evidence suggests that the program is an effective HIV risk reduction intervention for Latino youth. Moreover, since only 75% of adolescents interviewed for the study had actually been exposed to intervention activities or messages, the results may offer a conservative picture of the program's effectiveness.

The findings also offer no evidence that the promotion and distribution of condoms as part of an HIV education and prevention program will encourage sexual activity or promiscuity in the target population of Latino adolescents. Teens in the intervention city who were not sexually active prior to the intervention were no more likely to become sexually active than those in the comparison city. In fact, males in the intervention city were less likely than those in the comparison city to begin having sexual intercourse.

In interpreting the evaluation data, the researchers offered a few caveats. To begin, they noted that the small size of the treatment and comparison groups, and particularly the subgroups used in their analyses, make it difficult to detect significant differences. In addition, because only one intervention and one comparison city were included in the investigation, the findings should not be generalized to Latino teens in other parts of the country. Moreover, the exclusive focus on Latino youth makes it impossible to generalize the findings to youth from other ethnic groups. Yet, the data from this study suggest that future investigations in other cities and with other groups of teens would be valuable.

351

Evaluation Materials for *Poder Latino*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments*, the *Prevention Minimum Evaluation Data Set (PMEDS)* and a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

The *Original Evaluation Instruments* include both English and Spanish versions of the interviews used at the baseline and follow-up assessments. Both instruments probe the teen's experiences and enrollment in school, family environment, social supports from family and peers, sources of information and knowledge about HIV/AIDS, sexual history and use of contraception. Consent forms for the teen, as well as a parent/guardian, are also included at the front of each packet. At the back are a brief set of questions probing the interviewer's perceptions of the respondent's honesty and comfort with the survey, along with handcards for facilitating responses to particular items. Please note that the original study was conducted with Latino teens, and you may find that some questions need to be changed for use with other populations.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Poder Latino*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants of teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name

20

Rikers Health Advocacy Program (RHAP)

An Adolescent STD/HIV/AIDS Prevention Program

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Program Abstract

Title **Rikers Health Advocacy Program (RHAP)**

Summary

This program was originally developed for use with incarcerated male adolescent drug users, who may be detained in custody only briefly. The intensive, short-term intervention consists of four one-hour, small-group sessions focusing on health education issues, particularly HIV/AIDS. Adapting techniques of Problem Solving Therapy, the facilitator guides eight-person groups in discussing the following topics: general health, HIV and AIDS, drug abuse and its consequences, sexual behavior, health and AIDS risk behaviors and strategies for seeking health and social services. The discussions provide opportunities for participants to define high-risk attitudes and behaviors, suggest alternative actions and complete challenging "thought teaser" exercises that are designed to help the teens reflect on the reasons underlying their high-risk behaviors.

A field study of the program compared changes in the attitudes and behaviors of *RHAP* participants with those of a comparison group of teens, selected from a waiting list for the program. Both samples were predominantly African-American and Hispanic. Following the intervention, program participants expressed more favorable attitudes toward condoms, and were more likely to use condoms during intercourse, as compared with the comparison group of teens.

Focus ☐ Primary pregnancy prevention ☐ Secondary pregnancy prevention ☑ STD/HIV/AIDS prevention

Original Site ☐ School-based ☑ Community-based ☐ Clinic-based

Suitable for Use In

RHAP is appropriate for school- or community-based programs serving high-risk teens, especially drug users and incarcerated youth. Although it was initially targeted toward males, the curriculum could be used with females. Single-sex discussion groups are recommended.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach

☐ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☑ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age, Gender	The original sample included 110 incarcerated, drug-using males, ages 16 to 18 years (avg.=17.8).
Race/ Ethnicity	64% African-American, 33% Hispanic, 3% White

Program Components

☐ Adult Involvement
☐ Case Management
☑ Group Discussion
☑ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☐ Role Play
☐ Video
☐ Other __________

Program Length

This is a two-week, four hour intervention. Two one-hour group sessions are held each week.

Staffing Requirement/ Training

One leader is required for each group of approximately eight participants. Leaders should be the same sex as the teens in their group; they must also be comfortable working with high-risk youths and knowledgeable about HIV and drug use/abuse. For training, a thorough review of the curriculum and strategies for facilitating group sessions is recommended.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of the book for your convenience.

Program Rationale and History

The *Rikers Health Advocacy Program (RHAP)* focuses on health education issues, especially HIV/AIDS, that are relevant to incarcerated, drug-using teenagers. Based on Problem Solving Therapy, the curriculum introduces knowledge about general health, transmission and prevention of HIV/AIDS, drug abuse and sexual behavior, and teaches teens how to seek health, social and drug treatment services. The four-session program is structured around small group discussions with up to eight inmates.

A field study of the program was conducted between 1991 and 1992 at the New York City Department of Correction's Adolescent Reception and Detention Center on Rikers Island. Participants were predominantly African-American and Hispanic, heterosexual and 16-18 years of age. Over one-half had been arrested at least once before, and one-fifth reported five or more arrests. Funding for the study was provided by the National Institute on Drug Abuse.

Theoretical Framework

Problem Solving Therapy is the multi-step approach used to structure *RHAP's* group discussions (D'Zurilla, 1988). It appears to be relatively effective when applied in rapidly changing populations—including incarcerated, drug-using adolescents detained for varying periods of time—to reduce drug use and other high-risk activities.

The therapeutic process begins with problem orientation. Group members share and discuss facts and beliefs about the relevant problem, which in this case is HIV/AIDS. The next steps are to define and formulate the problem and then pinpoint specific attitudes and behaviors that must be modified to protect oneself and others from HIV/AIDS. At this stage of the therapy, participants generate alternative solutions by suggesting potential courses of action. Then, during the decision-making step, group members evaluate the strengths and weaknesses of these alternative solutions.

The closing phase of Problem Solving-Therapy is solution implementation. Usually this step is carried out though role plays and rehearsal techniques. However, in *RHAP,* a cognitive re-framing exercise is used. The facilitator introduces a situation that is relevant to the everyday lives of high-risk adolescents, and the youth are asked to consider their solutions. Typically, the youth are asked to think about a common event among abusers of illicit, highly addictive substances that results in high-risk behavior. Later, the facilitator helps participants identify the contradiction between their values and actions. It is hoped that reflecting on this contradiction will lead participants to make positive changes in their behavior.

Program Objectives

RHAP aims to reduce the risk of HIV/AIDS and increase knowledge about health, drug use and sexuality among incarcerated teenagers. Specifically, the curriculum addresses the following five objectives:

(1) to help participants examine the concept of health, and determine what they can do to maintain and improve their health and prevent disease in their own lives;

(2) to learn the basics about HIV and AIDS and how they affect one's life;

(3) to learn how HIV and AIDS are transmitted;

(4) to learn why people begin and continue using drugs; to recall positive and negative aspects of drug use; to outline options to drug use and summarize safer methods of using drugs, if one "must" continue to use; and

(5) to explore the meanings of sex in one's life, including both positive and negative aspects; to learn how sex-related health problems can be avoided.

Program Schedule

The curriculum is delivered in a small-group format with eight inmates in each group. Four small-group sessions should be held for one hour each, twice a week. Although a longer intervention might be helpful, it is impractical in most jails because youths are typically detained in custody for only a few weeks. A brief overview of the sessions appears below.

Description of Program Sessions

Session 1: Introduction

In the first session, the educator introduces the goals of *RHAP* and establishes ground rules for the group. Participants are encouraged to introduce themselves by relating the first quality about themselves they would like a stranger to know. Although the group discussion can vary with participants' concerns, the facilitator makes certain to address the topics of general health, HIV/AIDS, drug use and sex and sexuality. Toward the end of the discussion, participants are asked to classify various types of health and consider how their health concerns affect their individual lives. The facilitator should set aside ten minutes to summarize the content of the discussion and invite participants to discuss their goals for the next three sessions.

Session 2: HIV and AIDS

This session is designed to assess participants' knowledge about HIV/AIDS and to determine the changes that participants and their peers are making in response to the epidemic. It is suggested that the facilitator encourage the youth to be as specific as possible in discussing the impact of HIV/AIDS on their drug-using subculture. The first part of this session concludes with a "thought teaser." Participants are asked to reflect back to the day before they first used drugs. They are asked whether they had thought they would begin using drugs at that time. During the second half of the session, basic facts about HIV/AIDS are explained using analogies to a foreign army's invasion and to crowd behavior during a riot. Together the group discusses specific symptoms of the virus, comparing them to similar responses that arise from drug use. Routes of transmission are also explained. The session concludes with a review of modes of HIV transmission, including sharing needles, using a needle already used by someone else, an accidental needle stick, tattooing and ear and nose piercing.

Session 3: Drug Use

At the beginning of this session, participants share their responses to the thought teaser introduced in Session 2. The rest of the session is devoted to a discussion of drugs, the consequences of their use and ways to quit or use more safely. After probing how and with whom the youth started using drugs, and how experimentation turned into regular use, the facilitator asks which specific drugs were refused and how people resisted them. Then the facilitator lists reasons why people continue to use drugs and the negative consequences of drug use. At this point, the discussion shifts to the impact of drugs on health, and the problems associated with quitting. After indicating that there are two options—either continuing or stopping use—the facilitator reviews the safest strategy if a participant must continue to use drugs. S/he then summarizes the options for those who want to stop using. Finally, the facilitator introduces a new thought teaser. In this scenario, each participant is asked to imagine that his sister (or mother or girlfriend) performed oral sex on a friend in exchange for crack cocaine.

Session 4: Sex

Returning to the thought teaser introduced in Session 3, the facilitator asks how participants would respond to the scenario. From this discussion group members explore the meanings and experiences of sex, including both positive and negative aspects. The facilitator emphasizes practical ways to avoid sex-related health problems and asks whether participants or their acquaintances have encountered difficulties with condoms. Finally, the group is asked to consider whether drugs and sex meet some of the same human needs.

Program Materials: Replicating or Adapting *Rikers Health Advocacy Program*

The *Rikers Health Advocacy Program* can be obtained from the Program Archive on Sexuality, Health & Adolescence. See the Order Form at the back of the book. The program package includes the following materials needed to implement this program. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Protocol Handbook

Rikers Health Advocacy Program (RHAP) Group Protocol (also referred to as the *Protocol Handbook*). This handbook provides comprehensive plans for all four group sessions. Included in the booklet are objectives, activities, rules, facilitator and participant roles and "thought teasers." A series of discussion questions may help focus participants' attention in thinking about their use of drugs and involvement in crime. Clear descriptions of HIV/AIDS, modes of HIV transmission, causes and consequences of drug use, alternatives to drugs and the positive and negative aspects of sex can be photocopied and given as handouts.

Additional Materials

The PASHA program package provides everything needed to implement *RHAP,* except for a photocopier, which should be available at your institution. You will need the photocopier if you decide to give participants copies of some of the pages included in the *Protocol Handbook*.

How to Implement the Program

Facilitators should read the *Protocol Handbook* prior to the start of the first session. It describes all of the activities and offers suggestions for leading group discussions.

Establishing Ground Rules

Procedures for establishing ground rules are explained on page 1 of the *Protocol Handbook*. Facilitators are advised to convey the principles listed below.

(1) Confidentiality. To ensure that participants feel safe and comfortable sharing their thoughts and feelings, all comments are confidential. Neither the staff nor inmates should ever divulge any information to the correctional staff or anyone else. Nevertheless, in the original field study, a guard was stationed outside the room. Participants were reminded that the grate in the middle might allow sounds to pass, and they were discouraged from discussing specific infractions that may have occurred in the facility.

(2) Everyone's thoughts and feelings are okay. As long as they are not trying to hurt anyone, participants have a right to their own opinions. No one should be criticized or judged for their feelings.

(3) It is okay not to talk. A participant can say "I pass," if s/he does not want to share something with the group. At the same time, the more people share, the more everyone will learn from the discussions.

(4) Participants should talk one at a time. They should not interrupt others or start side conversations. They should pay attention to whoever is speaking. Such behavior will encourage all participants to pay attention and show respect to one another.

(5) Participants should be encouraged to express their emotions. When participants support one another, the whole group can feel supported. Teens should not be afraid to let others know what they need from them.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the original *Rikers Health Advocacy Program (RHAP)* was investigated in a field study conducted with adolescent drug users in jail. The study was carried out in 1991 and 1992 at the New York City Department of Correction's Adolescent Reception and Detention Center (ARDC) on Rikers Island.

From a pool of volunteer inmates, the researchers constructed two empirical groups: (1) program participants and (2) youth who were put on a waiting list for the program. *RHAP*'s effectiveness was investigated by comparing the two groups' scores on several measures of risk behavior, including use of alcohol and non-injecting drugs, frequency of sex with multiple and high-risk sexual partners, frequency of anal sex and frequency of condom use in various contexts.

To assess the impact of the program over time, individual face-to-face interviews were conducted with all teens at two points:

- Time 1: At the start of the intervention (pre-test); and
- Time 2: About ten months later (five months after release from jail) (follow-up).

Evaluation Questions

Two empirical questions guided the field study.

(1) Does participation in *RHAP* reduce the frequency of alcohol and non-injecting drug use among teens?

(2) Does program participation reduce the frequency of risky sexual behaviors among teens?

Data Collection Procedures

Participants in this study were all recruited from the New York City Department of Correction's Adolescent Reception and Detention Center on Rikers Island. At the start of the field study, the correctional authorities directed the researchers to 11 diverse dormitories housing young men who: (1) had recently been admitted to the facility; (2) were in protective custody; (3) had already been sentenced; or (4) were awaiting judicial action.

In a series of visits to each dormitory, the research staff introduced the study to the inmates in residence. They explained that participation was voluntary, all information would be confidential and the project was completely independent of the correctional system. Youth who were interested in participating were asked to sign an informed consent form that was consistent with federal human subjects regulations for prisoners and minors in custody. Additionally, the research plan had been approved by the evaluators' Institutional Review Board, and the data were protected by a Federal Certificate of Confidentiality.

All volunteers were interviewed. Two African-American and one Hispanic paraprofessional, who were in recovery from addiction and had personal prison experience, conducted both the Time 1 and Time 2 interviews. The researchers believed that the similar cultural backgrounds and detention experiences of the interviewers and inmates might promote greater honesty by the youth. The semi-structured interviews included questions about socio-demographics and family background, alcohol/drug use patterns, drug dealing, involvement with criminal justice, sexual behaviors, psychological status and attitudes toward crime, drug use and AIDS; typically they lasted about 90 minutes.

Following the Time 1 interviews, the two groups of teens—*RHAP* participants and comparison group members— were constructed. Because prison officials were concerned about youths' reactions if they were not offered the opportunity to participate, random assignment to the groups was not employed. Instead, a convenience sample was constructed; the first set of interviewees served as program participants while the remainder were put on a waiting list. Many on this list were released from jail or were transferred within the detention facility before they could participate in the program.

Participants received $10 for completing the Time 1 interview, $5 for attending each group session and $30 for the final, Time 2 interview. The in-jail payments were credited to the participants' commissary accounts.

Sample

The research staff completed Time 1 interviews with 411 incarcerated youth. Of this sample, 110 became program participants. Due to budgetary constraints follow-up data were collected only for 58 early program participants and 99 comparison group members.

The median age of the final sample was 17.8 years. In addition, participants were primarily African-American or Hispanic, heterosexual, living with parents or grandparents and not attending school at the time of their arrest. More than half of the participants had been arrested at least once before, and about one-fifth reported five or more arrests. Their offenses included drug dealing and possession, murder, attempted murder, robbery, assault, arson and rape, but property offenses and possession of weapons were the most common charges at arrest.

Since youths who were sentenced and transferred to state prison were not eligible or available for follow-up, the final sample probably underrepresents the most serious or persistent offenders in the population. Overall, the follow-up completion rate was 66% (i.e., number interviewed/number targeted); the researchers found no statistically significant differences on background variables between the youths who participated in *RHAP* and those who did not.

Evaluation Results

Time 1 Assessment

At the Time 1 assessment, the youths reported a high degree of involvement in risky behavior, including frequent use of alcohol and marijuana. Twenty-four percent had used cocaine in some form during the month before arrest, although only 3% reported heroin use and none had used IV drugs. Also during the month prior to their arrest, 98% of the youths engaged in heterosexual intercourse an average of 3.7 days a week. Three-fourths had multiple sex partners, 10% had high-risk sexual partners and about 30% engaged in heterosexual or homosexual anal sex. About one-fifth never used a condom during sex, and two-thirds used condoms inconsistently, though most (about 66%) carried them regularly.

At the start of the study, the researchers found no statistically significant differences between the behaviors of *RHAP* participants and members of the comparison group.

Follow-Up Assessment

Effects on Condom Use

Ten months after the intervention, *RHAP* participants used condoms significantly more often than their comparison group peers. This outcome was observed for condom use in general, and specifically during vaginal intercourse and oral and anal penetrative sex. The magnitude of the differences between the two groups ranged from 0.6 to 1.0 points on a six-point scale.

Effects on Number of High-Risk Sexual Partners

Program participants reported slightly fewer high-risk sexual partners at the follow-up assessment (p = .06), as compared with members of the comparison group.

Effects on Condom Acceptability

The researchers hypothesized that changes in the youths' attitudes towards condoms would parallel changes in their actual condom use. After constructing a measure of condom acceptability, they confirmed this supposition. That is, program participants expressed more favorable attitudes toward condoms than did their comparison group peers.

Effects on other Risky Behaviors

On measures of the teens' use of alcohol and non-injecting drugs, number of sex partners and frequency of sex, no significant differences were found between the two groups following the intervention.

Summary

The *Rikers Health Advocacy Program,* a four-session HIV/AIDS prevention program incorporating techniques of Problem Solving Therapy, was found to be effective in reducing some of the high-risk behaviors of incarcerated adolescent drug users. In particular, program participants reported significantly greater use of condoms, both in general and during high-risk acts. In addition, the reduction in high-risk sexual partners fell just short of significance. However, no change was found in other high-risk behaviors practiced by these teens, including the use of alcohol and drugs and sex with multiple partners.

Although *RHAP* proved effective in increasing youths' preventive behaviors and attitudes, open-ended responses to the interview questions revealed that concerns about contraception and other (non-HIV) sexually transmitted diseases—particularly in contacts with casual partners—helped motivate the youths' increases in condom use. In interpreting their results, the researchers concluded that the youths did not personalize AIDS as a threat, but rather saw it as a problem among other groups, such as gays, adult "crackheads" and "junkies." Consequently, to prevent HIV from expanding into this highly vulnerable population of teens, the researchers called for intensive, community-based interventions that are designed to integrate the youth into the larger society.

Evaluation Materials for *Rikers Health Advocacy Program*

In addition to the program materials described in an earlier section, the PASHA program package includes three resources for evaluation: (1) the interview protocols used in the original evaluation; (2) the *Prevention Minimum Evaluation Data Set (PMEDS);* and (3) a *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites with new groups of teens

Original Evaluation Materials

The interview protocols used in the field study of the program are provided in two yellow packets: the *Original Evaluation Instruments: Baseline Interview* and the *Original Evaluation Instruments: Follow-Up Interview*. In both instruments, questions probe the youths' experiences with alcohol, marijuana and crack cocaine, multiple sex partners, high-risk sexual partners, anal sex, condom use in general and during oral, anal, and vaginal sex, condom accessibility and condom acceptability. Additional questions ask about the teens' involvement in the drug trade, prior arrests, employment history, living arrangements and history of physical and sexual abuse, if any. Finally, there are questions about the teens' school enrollment, attendance, conduct and grades. Although the two interviews are similar, the follow-up instrument stresses possible changes in inmates' behaviors that could lessen their risk for HIV. Please note that the original study was conducted with a male, African-American and Hispanic group of teens with prior arrest records. You may find that particular items may need to be changed when using the survey with other populations, including female adolescents.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *RHAP*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants of teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

21

Safer Sex Efficacy Workshop

An Adolescent STD/HIV/AIDS Prevention Program

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Basen-Engquist, K. (1994). Evaluation of a theory-based HIV prevention intervention for college students. *AIDS Education and Prevention*, 6(5), 412-424.

Program Abstract

Title

Safer Sex Efficacy Workshop

Summary

This three-hour workshop is designed to increase college students' self-efficacy, or belief in their own ability to act successfully to prevent HIV/AIDS and other sexually transmitted diseases. Drawing upon social learning theory, the program includes numerous role-play and skill-building exercises, and is led by peer educators who are trained to serve as persuasive models. To give students the knowledge necessary to practice preventive behaviors, the leaders begin by facilitating a group discussion about HIV/AIDS and STDs, including transmission and prevention. During the next section, participants discuss personal experiences of and feelings about AIDS and other STDs. Finally, the students role play safe-sex discussions and learn about correct condom use, gaining confidence in their abilities in the process. A field study of the workshop was conducted with 209 undergraduate students enrolled in a health education class at the University of Texas. Compared to comparison groups of their peers, program participants showed significant increases in self-efficacy at the two-month follow-up assessment. Sexually active students also showed an increase in their frequency of condom use.

Focus

☐ Primary pregnancy prevention
☐ Secondary pregnancy prevention
☑ STD/HIV/AIDS prevention

Original Site

☑ School-based
☐ Community-based
☐ Clinic-based

Suitable for Use In

Although it was originally implemented in a college setting, this program is also suitable for use with young adults ages 18-22 in other educational settings or community-based organizations.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☐ Contraceptive Access
☑ Contraceptive Education

- ☐ Life Option Enhancement
- ☑ Self-Efficacy/Self-Esteem
- ☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age	Among the 209 college students participating in the study, the average age was 22 years.
Gender	67% Female
Race/ Ethnicity	82% White

Program Components

- ☐ Adult Involvement
- ☐ Case Management
- ☑ Group Discussion
- ☐ Lectures
- ☑ Peer Counseling/Instruction
- ☐ Public Service Announcements
- ☑ Role Play
- ☐ Video
- ☐ Other ________

Program Length

The single-session workshop is designed to last between 2 1/2 and 3 hours.

Staffing Requirements/ Training

Two peer educators are recommended to lead each ten- to fifteen-person group. During the original field study, a 20 hour training program was held to introduce the peer educators to basic concepts of the curriculum, as well as HIV/AIDS, STDs and group process skills.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

The *Safer Sex Efficacy Workshop* is a college-level intervention designed to prevent HIV/AIDS and STDs by increasing students' self-efficacy, or belief in their ability to protect themselves from infection. Adapted from the "Eroticizing Safe Sex" guide by the Gay Men's Health Crisis, the three-hour workshop includes small group discussion, role play activities and review of basic facts about HIV/AIDS transmission and prevention. Moreover, the program is guided by Social Learning Theory and uses specially trained peer leaders to communicate the importance of safe sexual practices.

A field study of the program was conducted with 209 undergraduate students enrolled in a health education class at the University of Texas. Funding for the study was provided by the American Psychological Association.

Theoretical Framework

The *Safer Sex Efficacy Workshop* is grounded in Social Learning Theory. This theory is based on the idea that knowledge alone is insufficient to produce behavioral change. Instead, the theory points toward four factors that together determine the likelihood of engaging in some action, such as using condoms to protect oneself from HIV/AIDS: (1) a person's understanding of what must be done to avoid infection; (2) the belief that one will be able to use condoms; (3) the belief that the method will be successful in preventing HIV/AIDS; and (4) the benefit one anticipates from accomplishing the behavior (e.g., staying healthy).

To enhance participants' self-efficacy, the program includes mastery experiences, or practice in successfully completing a task (e.g., negotiating with one's partner and using condoms); role modeling, or watching others similar to ourselves perform the task successfully; and social persuasion, which refers to information received from others that one can perform a task successfully. Following principles of Social Learning Theory, the workshop is led by peer educators who are trained to serve as persuasive and appealing models.

Program Objectives

As an STD/HIV/AIDS risk reduction program, the *Safer Sex Efficacy Workshop* is designed to help participants:

(1) acquire the information they need to make informed choices about protecting themselves from HIV/AIDS and other sexually transmitted diseases;

(2) acquire the skills needed to act on those choices;

(3) feel more comfortable talking to their sexual partners about safer sex; and

(4) discover that safer sex does not have to be boring or much trouble—instead, it can be fun and allow participants to be creative.

Underlying Principles of the Workshop

All workshop activities and lessons reinforce three principles:

- sex is healthy;
- the way in which individuals protect themselves from HIV/AIDS and other STDs should be an informed choice, not one made out of fear and ignorance; and
- changing sexual behavior is not easy, but it can be done if individuals develop the necessary skills and receive support in the process.

Teaching Strategies

Activities in the *Safer Sex Efficacy Workshop* emphasize mastery experiences, role modeling and social persuasion, as explained below.

- Mastery Experiences: Students repeatedly practice negotiating and discussing issues regarding safer sex. The program is premised on the idea that after gaining confidence in their abilities, students should be able to apply these skills in their own relationships.
- Role Modeling: Peer instructors serve as role models, demonstrating techniques for using condoms, comfortably conversing about safer sex and negotiating safer sex with a partner. In addition, students also serve as models to one another as they do role plays.
- Social Persuasion: Throughout the workshop, the peer instructors encourage participants, offer feedback and discuss the importance of safer sex.

The three-hour workshop is divided into five segments. Brief overviews of the segments appear below. Comprehensive lesson plans can be found in the *Safer Sex Efficacy Workshop Instructor's Handbook* which is included in the PASHA package.

Program Schedule

Description of Workshop Segments

I. Introduction

After the facilitator reviews the goals and guidelines of the workshop, each student pairs off with someone s/he does not know. The participants spend about 5-10 minutes getting to know one another, and then introduce their new acquaintance to the group.

II. AIDS Information, STD Information and Personal Risk

The facilitator leads the group in a discussion of basic facts about HIV/AIDS and other STDs, focusing on how the diseases are and are not transmitted, and the best way individuals can protect themselves from contracting HIV, gonorrhea, chlamydia and other illnesses. Discussion then shifts to students' vulnerability to infection, even if they are not a member of a high-risk group. This section of the workshop concludes with an activity designed to help participants calculate their risk for STDs by adding or subtracting points for various sexual behaviors in which they may have engaged.

III. Discussion of AIDS and Safer Sex

During this segment of the workshop, participants are encouraged to discuss the impact of HIV/AIDS and other STDs on their own lives. Shifting to disease prevention, the facilitator first lists various preventive behaviors (e.g., abstinence, using condoms). Then students are asked to consider the five most significant barriers that hamper individuals from following prevention strategies. Working in small groups, participants brainstorm to identify ways they might overcome each of the barriers.

IV. Talking about Safer Sex with Partners and Others

After a brief break, the focus shifts to strategies for negotiating safer sex with one's partner. The instructor divides participants into four-person teams; these teams enact various role plays involving sexual decision-making. Following the role plays, the

facilitator brings the groups together to discuss and review what they have learned.

V. Making Safer Sex Fun

The next section of the workshop begins with a demonstration of the correct way to use a condom. The participants consider ways they might explore having safer sex in a satisfying manner. Finally, the instructor reminds students about the importance of maintaining confidentiality concerning the workshop discussions.

VI. Closing

Before participants leave, the facilitator answers any remaining questions and hands out educational brochures on HIV/AIDS and safer sex.

Program Materials: Replicating or Adapting *Safer Sex Efficacy Workshop*

The *Safer Sex Efficacy Workshop* can be obtained from the Program Archive on Sexuality, Health & Adolescence. See the Order Form at the back of the book. The following materials are needed to implement the *Safer Sex Efficacy Workshop* in your college, university, or community-based organization. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Curriculum Materials

The Safer Sex Efficacy Workshop Instructor's Handbook. This handbook provides the complete curriculum for the workshop, along with an explanation of the purpose of each activity and the overall framework for the program. Also listed are the materials and the suggested time needed to complete each activity.

Additional Materials

The PASHA program package provides everything needed to implement the *Safer Sex Efficacy Workshop,* except for the following materials, which should be available in your school or community: a photocopier, large newsprint pad, easel, markers, paper and pencils, tape, smaller pads of paper, and condoms. Complete instructions for preparing large newsprint posters that are used in various activities can be found in the *Instructor's Handbook.*

How to Implement the Program

During the original field study, a 20-hour training program was held to prepare educators to lead the workshop. The training included a discussion of basic facts about HIV/AIDS and other STDs, as well as the specific skills required to lead the program. You may organize a similar event for your staff, or rely on the *Instructor's Handbook,* which provides a comprehensive overview to the program.

Regardless of the training method selected, facilitators should review all of the program materials described above prior to the start of the workshop. In addition, the following pointers for establishing ground rules and facilitating role play activities should prove helpful.

Establishing Ground Rules

Ground rules for group discussions should be established at the start of the workshop session. This will help create an atmosphere of trust and comfort in which students feel free to discuss issues concerning sexuality and protection from sexually transmitted diseases, with a particular focus on HIV/AIDS. Procedures for establishing ground rules are explained in the *Instructor's Handbook*. Instructors are advised to follow four principles:

(1) Confidentiality. Participants should not repeat outside of the workshop any of the comments offered by students during the session. However, they are free to discuss with friends the content of the program itself.

(2) Participants should be encouraged to use "I" statements during group discussions. These kinds of statements help people appear more warm and personable to others.

(3) Group leaders and workshop participants should remember that sexual behavior represents a personal choice—there will be a wide range of sexual experiences and practices among group members. For this reason, it is best not to be judgmental about others' behaviors.

(4) Participants should be discouraged from censoring anything they may be thinking. In this way, the workshop will be more spontaneous and meaningful for students.

Importance of Role Playing

Practicing newly-learned skills is a critical piece of the *Safer Sex Efficacy Workshop*. A series of role-play activities are designed to encourage participants to talk more easily with their partners and others. The workshop participants are divided into teams of four. In each team, two people role play four scenarios, while the other two people remain silent and observe. After enacting the scenarios, the whole group discusses several questions probing their feelings, observations and evaluation of the strategies used to negotiate safer sex. This process reinforces participants' ability to communicate clearly and forcefully in romantic encounters. Several positive comments that instructors can offer participants are provided in the *Instructor's Handbook*.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the *Safer Sex Efficacy Workshop* was investigated in a field study conducted with 209 students enrolled in an undergraduate health education class at the University of Texas. Volunteers were randomly assigned to take part in one of three interventions: (1) the *Safer Sex Efficacy Workshop*; (2) a didactic lecture on HIV that contained the same information as the workshop, but without mastery experiences, role modeling, or social persuasion; or (3) a lecture on an unrelated topic, family violence.

The study compared the three groups of students on measures of self-efficacy, behavioral intentions and actual behaviors. To measure the impact of the workshop over time, a series of self-report questionnaires were administered to all participants. Behavioral outcomes were measured at all three points listed below, but the cognitive outcomes were measured at Times 1 and 2 only:

- Time 1: Before the intervention began (pre-test);
- Time 2: At the conclusion of the intervention (post-test); and
- Time 3: Two months following the intervention (follow-up).

Evaluation Questions

The study was designed to examine the effects of the *Safer Sex Efficacy Workshop* on students' self-efficacy, behavioral intentions and actual behaviors regarding safer sex. The researcher hypothesized that workshop participants, compared to their peers attending the HIV and family violence lectures, would show higher self-efficacy and stronger intentions to practice safer sex following the intervention. Additionally, it was predicted that workshop participants would show higher levels of actual safe sex behavior at the follow-up assessment, two months later.

Data Collection Procedures

All students enrolled in an undergraduate health education class at the University of Texas were given the option of participating in the study or writing a short paper to fulfill a course requirement. All opted to participate in the study.

The students were randomly assigned to take part in the *Safer Sex Efficacy Workshop*, or either of the two comparison interventions: the didactic HIV lecture or the family violence lecture.

Data collection was anonymous and confidential. Each participant's pre-test, post-test and follow-up questionnaires were linked by a code number formed by combining digits from the student's social security and telephone numbers.

Sample

Of the 209 participants who completed the pre-test, 174 attended the intervention and provided complete data for the remaining two assessments. The sample included more female than male participants, and was predominantly White and heterosexual. On average, participants were slightly under 22 years of age.

Analysis of the behavioral measures was conducted only for those participants who provided complete data at all three assessment periods. After the participants with incomplete data were dropped, the final sample for the behavioral analysis included 67 participants who had sex in the previous two months at pre-test, post-test and follow-up. Those who had not had sex at any of the time points were not included in the behavioral analysis.

Evaluation Results

At the Time 1 assessment, there were no significant differences among the three groups on any of the cognitive measures. However, students in the family violence lecture group did report more frequent use of condoms than did their peers assigned to take part in the *Safer Sex Efficacy Workshop*.

Effects on Self-Efficacy

Compared to their peers attending the family violence lecture, participants attending the *Safer Sex Efficacy Workshop* and the HIV lecture both showed significant increases on measures of self-efficacy from the Time 1 to Time 2 assessments.

Effects on Intention to Use a Condom

Again, compared to their peers attending the family violence lecture, both the *Safer Sex Efficacy Workshop* and the HIV lecture participants showed significant gains from the Time 1 to Time 2 assessments.

Effects on Intentions to Communicate about Safer Sex

The *Safer Sex Workshop* did not appear more effective than the other interventions in increasing students' intentions to discuss AIDS and their sexual history with their current sexual partners. During the brief (less than two week) period from the Time 1 to Time 2 assessments, students in all three groups showed increases on these measures.

Effects on Safer Sex Behavior

During the two-month follow-up period, workshop participants increased their frequency of condom use more than their comparison group peers. But the degree of improvement was small—on a 5-point scale it rose from a mean of 1.7 (between never and rarely) at Time 1 to a mean of 2.2 (between rarely and occasionally) at the Time 3 assessment ($p<.019$).

Summary

Immediately following the intervention, participants in the *Safer Sex Efficacy Workshop* showed increased self-efficacy and intention to use condoms in future sex acts. However, the same material, when delivered in a traditional, didactic format, appeared to have the same effect on students' self-efficacy and intentions concerning safer sex. The comparable results for the workshop and HIV lecture may be attributed to the presence of efficacy-boosting elements in both interventions. Because the same peer instructors delivered all of the interventions, they may have unintentionally served as role models to students. Although present to a lesser degree in the HIV lecture, such role modeling could have been sufficient to strengthen the participants' self-efficacy and intentions regarding safer sex.

The workshop did appear to be more effective in increasing students' actual use of condoms, though only modestly. The small degree of change may be due to the limited, single-session structure of the program. A similar approach, applied over a longer period of time, might show greater effect on participants.

Moreover, in interpreting the results, the researcher noted that at the time of the field study, there was growing awareness of the risk of HIV/AIDS for those outside high-risk groups. Consequently, the importance of safer sex communication might have already been salient for students, regardless of the intervention in which they took part.

Evaluation Materials for *Safer Sex Efficacy Workshop*

In addition to the program materials described in an earlier section, the PASHA program package includes three resources for evaluation: (1) the questionnaires used in the original evaluation of the program; (2) the *Prevention Minimum Evaluation Data Set (PMEDS)*; and (3) the *Local Evaluator Consultant Network Directory*.

Original Evaluation Materials

The questionnaires used in the field study of the program can be found in the *Values, Attitudes and Intentions Inventory* and the *Behavior Questionnaire*, as described below.

Values, Attitudes and Intentions Inventory. This set of measures includes 48 questions probing students' self-efficacy; intentions to practice safer sex and discuss AIDS, STDs and past partners with their current sexual partner; and attitudes and beliefs concerning safer sex. A few background demographic measures are also included. The inventory was administered only at the Time 1 and Time 2 assessments.

Behavior Questionnaire. This survey includes 28 questions. Sexually active students are asked about their patterns of sexual activity and protective behavior during the previous two months. In addition, all respondents are asked about their attitudes toward various sexual behaviors.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Safer Sex Efficacy Workshop*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

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22

Youth AIDS Prevention Project (YAPP)

An Adolescent STD/HIV/AIDS Prevention Program

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Program Abstract

Title

Youth AIDS Prevention Project (YAPP)

Summary

Originally designed for high-risk youth, including African-Americans, *Youth AIDS Prevention Project (YAPP)* aims to prevent STDs, HIV/AIDS and substance abuse among junior high school students. Guiding the program is social cognitive theory, which targets teens' knowledge, attitudes, self-efficacy, intentions and behaviors regarding high-risk activities. The intervention includes ten sessions for 7th grade students, delivered in regularly scheduled health or science classes, and a five-part booster session offered one year later, when the teens have entered 8th grade. Classes cover transmission and prevention of STDs and HIV/AIDS, the importance of using condoms for those who choose to have sex, and the development of decision-making and resistance/negotiation skills. In addition to lectures and class discussions, active learning is emphasized, with opportunities for students to participate in small group exercises and role plays. There are also homework activities and opportunities for parental involvement.

A field study of the intervention was conducted in fifteen high-risk school districts in Chicago. Research focused on the group of students who first became sexually active during the study period. Following the booster session, these students reported less frequent sexual intercourse and greater use of condoms with foam in the past 30 days; they also expressed greater intention to use condoms with foam in the future.

Focus	☐ Primary pregnancy prevention	☐ Secondary pregnancy prevention	☑ STD/HIV/AIDS prevention
Original Site	☑ School-based	☐ Community-based	☐ Clinic-based

Suitable for Use In

This intervention is most suitable for 7th grade classrooms, with the five-lesson booster program offered in 8th grade classrooms one year later. The intervention could also be used in community-based organizations serving teens between the ages of 12 and 14 years.

Approach

☑ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☐ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☐ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age, Gender	The original group of program participants included 1,459 7th grade students, of whom 48% were male. The booster program for 8th grade students involved 1,001 teens.
Race/ Ethnicity	Approximately 58% African-American, 21% White, 16% Hispanic, 5% other.

Program Components

☑ Adult Involvement
☐ Case Management
☑ Group Discussion
☑ Lectures
☐ Peer Counseling/Instruction
☐ Public Service Announcements
☑ Role Play
☑ Video
☐ Other __________

Program Length

During the first year of the program, ten class sessions are offered, one per day over a two week period. A one week, five-session booster program should be held one year later. The lessons are designed to last approximately 40-45 minutes.

Staffing Requirement/ Training

Ideally, the program should be led by professional, master's level health educators who have received special training in HIV/AIDS; one instructor is required per class session. However, *YAPP* was designed for regular classroom teachers (with modest training) to deliver *YAPP* to their classes. This additional training is recommended to familiarize teachers with the *YAPP* curriculum.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

The *Youth AIDS Prevention Project (YAPP)* integrates human sexuality, drug, STD/HIV/AIDS and risk reduction education for junior high school students. Based on Social Cognitive Theory, the curriculum covers the transmission and prevention of STDs, HIV/AIDS, the use of condoms, pregnancy, and particularly, the development of decision-making and resistance/negotiation skills. The program is divided into ten lessons for seventh grade students and a five-lesson booster program for eighth graders. Additionally, several of the homework activities involve parents, and an optional adults-only education session may also be held.

Between 1991 and 1993 a field test of the program was conducted with approximately 2,400 students in 15 school districts throughout metropolitan Chicago. Compared to their peers in other areas of the city, students in the participating districts were considered to be at greatest risk for HIV infection. All program activities were originally designed to appeal to high-risk youth, including African-Americans, who comprised more than half of the participating teens. Funding for the study was provided by the National Institute of Mental Health.

Theoretical Framework

YAPP is guided by Social Cognitive Theory (previously referred to as Social Learning Theory).

Social Cognitive Theory is based on the idea that knowledge alone is insufficient to produce behavioral change. Instead, the theory points toward four components that must be included in any effective prevention program. The first component is informational, designed to increase knowledge. The second component targets the development of the social and self-regulative skills that a teen needs to translate knowledge into effective behavior. The third component focuses on developing skills and self-efficacy by providing opportunities for practice and corrective feedback in applying skills in high-risk situations. Finally, the fourth component is designed to strengthen the social supports available to help youth carry out the desired changes.

YAPP contains all four of these necessary components. First, the curriculum provides state-of-the-art HIV/AIDS-related information. Second, the program incorporates activities that help students build their resistance and negotiation skills. Third, role-play exercises provide teens with the opportunity to practice their newly acquired skills. Fourth, *YAPP* creates social supports for teens by involving peers, parents and the entire school in the program.

Program Objectives

As an STD/HIV/AIDS risk reduction program, the *Youth AIDS Prevention Project* is designed to help teens:

1. avoid high-risk behaviors (e.g., drug use, sexual intercourse before one is psychologically ready);
2. increase their AIDS-related knowledge, attitudes, self-efficacy and intentions; and
3. learn protective (e.g. correctly using condoms with spermicides) and avoidance (e.g. avoiding risky situations) behaviors as a result of their improved knowledge, skills and self-efficacy.

Program Schedule

Description of Program Sessions

Detailed outlines—along with tips and guidelines—for leading each 40-minute class lesson, as well as the optional parent session, are provided in the *Youth AIDS Prevention Project Seventh Grade Curriculum Manual* and the *Youth AIDS Prevention Project Eighth Grade Curriculum Manual.* Class objectives, learning components, student handouts, vocabulary lists and homework assignments are included.

The following five components are used throughout *YAPP* classes to reinforce program lessons.

- Anonymous Question Box: Students are given the opportunity to ask any questions they may have about STD/HIV/AIDS, sexuality and other related topics, without fear of being identified.
- Brainstorming: This technique is used during group discussions to allow students to feel that all opinions and thoughts are valued.
- Role Playing: Role-play activities encourage *YAPP* participants to experience real-life situations and practice new skills.
- Parent Interactive Homework: Several homework activities require that students and their parents work together to apply the information and skills taught in the program.
- Parent Workshop: This optional activity familiarizes parents with the curriculum and increases adults' awareness of

385

STD/HIV/AIDS and risky behaviors affecting teens. Although the program developers had originally planned a more extensive series of adult activities to accompany the parent workshop, they found that adults were unwilling or unable to take part.

A brief overview of the sessions appears below.

SEVENTH GRADE CURRICULUM

CLASS 1: Decision Making

At the start of this class, the teacher explains the ground rules that will govern group discussions and invites students to submit any questions they have throughout the program to the Anonymous Question Box. The class then considers the factors that influence teens' decision making (e.g., family, friends, boy/girlfriend, teachers, media, religion, school). Through role-play exercises, students are introduced to the SAFER method of decision making.

S = STUDY the problem and clarify the decision to be made.

A = List the ALTERNATIVES or choices you have.

F = FIND the best alternative/choice for you by considering the advantages and disadvantages of each one.

E = EXECUTE the plan (Do it!).

R = REVIEW and consider the outcome of your decision.

For homework, students are asked to think about two situations in which they must make decisions about risk-taking behavior and explain how their decision-making process for each. In addition, both students and their parents or guardians are also asked to complete a survey assessing their patterns of communication.

CLASS 2: Resistance/Negotiation Skills

At the start of this session the homework is reviewed and questions from the Anonymous Question Box are answered. (These same activities occur at the start of all subsequent lessons, as well.) This class is designed to help teens recognize that the importance of their decisions can vary. Working in small groups, students brainstorm to create a list of decisions and decide whether each is a big or small decision. Then the teacher introduces the six S's—resistance/negotiation skills that can guide one in reaching good decisions.

S = STOP, Look, and Listen.

S = SAY "No".

S = STATE your response repeatedly, and in different ways.

S = SUGGEST other things to do.

S = SAY "Good-bye".

S = STAY away.

Several role-play exercises are used to review the SAFER method of decision making and practice the six S's resistance/negotiation skills.

CLASS 3: A is for AIDS

This session provides students with basic factual information about HIV and AIDS, including transmission, infection, and prevention. Students learn that their risk of exposure to the HIV virus increases as they participate in risky behaviors. The class then watches and discusses the video, "A is for AIDS," which introduces the audience to the facts about HIV and AIDS.

CLASS 4: Prevention (Abstinence & Safer Sex)

During the first part of the class, abstinence is discussed as the only 100% certain method for STD/HIV/AIDS prevention. Together, the group explores alternative ways to express love and romantic feelings apart from sexual intercourse. Then the focus shifts to issues concerning sexuality, methods of contraception, pregnancy, and transmission of STD/HIV/AIDS. At the end of the period, the instructor leads a demonstration of the proper way to use condoms and foam.

CLASS 5: Whose Decision Is It?

Students identify and analyze the ways various media try to influence their decision making. They look not only at sexual messages, but also at the ways they may be persuaded to buy a product or wear a particular style of clothing.

CLASS 6: Teen AIDS

A group exercise and the video, "Teen AIDS in Focus," show students how quickly AIDS can be transmitted from person to person. The video also examines the lives, relationships, and goals of persons affected by HIV. For homework, students and their parents are asked to read a story about a high school athlete who asks several people for advice before deciding to use steroids. The assignment is to rank each character's responsibility for the athlete's problems resulting from his use of steroids.

CLASS 7: Prevention (Be Safe—Don't Do Drugs)

During this lesson, students examine the reasons why adolescents use drugs and the consequences that can result. A series of role-play activities reinforce participants' decision-making and resistance/negotiation skills in real life situations concerning drugs.

CLASS 8: STD: Stop That Disease

This lesson provides students with general information about STDs, including transmission and prevention. The group applies the SAFER decision-making method and the six S's resistance/negotiation skills in role play activities.

CLASS 9: Drugs and STDs

Focusing on ways to prevent STDs, the class again uses the SAFER decision-making method and the six S's resistance/negotiation skills in a series of role-play activities. In another activity called "Give me your best jive/line" students learn how to negotiate safer sex practices and consider delaying sexual intercourse until they are emotionally and mentally ready. For homework, students are asked to write a newsletter column for a school newspaper giving advice about risk-taking choices and decisions.

CLASS 10: Program Review

The final session of the seventh grade program is designed to help students integrate the information and skills they have learned concerning STD/HIV/AIDS, drugs, and human sexuality. In a group activity, students divide into two teams and answer questions about each of the topics covered in the curriculum.

OPTIONAL PARENT WORKSHOP

A separate 60- to 90-minute-session may be held for parents and guardians of seventh grade students participating in the *YAPP* program. The session is designed to introduce parents to the curriculum, discuss current trends in sexual activity and drug use among teens, and encourage parents to talk about sexuality and risk behaviors with their children. The video "A is for AIDS," shown during lesson 3, is also presented to parents.

EIGHTH GRADE CURRICULUM

LESSON 1: Making Decisions

During the first lesson of the eighth grade booster program, students review the ground rules that will govern each of the class discussions. They are also invited to submit any questions they have to the Anonymous Question Box. A poster reviews the SAFER decision-making method and the six S's resistance/negotiation skills. These concepts are reinforced through role play activities concerning pressure to have sex and engage in risky behaviors. Students may also create their own skits. For homework, students are asked to write their autobiographies, imagining themselves at a point five years in the future.

LESSON 2: Sexuality and STDs (HIV/AIDS)

After answering students' questions from the Anonymous Question Box, the instructor summarizes key information, including myths and facts, about transmission, prevention, and infection of HIV/AIDS and other STDs. The group then divides into two- to four-person teams to review case studies concerning risks for exposure to HIV/AIDS. For each case, the teams answer a series of questions asking about the decisions the characters would have to make.

LESSON 3: Relationships, Abstinence & Safer Sex

This lesson aims to help students understand and manage healthy relationships. At the beginning of the period, the instructor asks students to brainstorm about their various relationships and the reasons for beginning them. The risks of gang involvement are also discussed. In the second part of the class, the instructor leads a demonstration of the correct way to use condoms with foam.

LESSON 4: Preventing Risky Behaviors

In this lesson the SAFER method of decision making and the six S's of negotiation/resistance skills are reinforced again through several role plays involving sexuality and drugs. Key facts about drugs and STDs are also reviewed by the class.

LESSON 5: Ready for the Future

The final lesson is designed to integrate all of the *YAPP* lessons concerning HIV/AIDS, other STDs, drugs, and human sexuality. Students reconsider the autobiographies they wrote earlier in the program, focusing on factors that might interrupt their plans. Leading a group discussion on the transition to high school, the instructor asks students to think about the new groups of people they will meet, and the situations and pressures they may encounter. Teens are reminded to apply the decision-making and resistance/negotiation skills they have practiced throughout the program.

Program Materials: Replicating or Adapting *Youth AIDS Prevention Project*

The *Youth AIDS Prevention Project* program package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of the book. The program package for the *Youth AIDS Prevention Project* includes the following materials needed to implement this program in your community or school. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

7th Grade Program Materials

The *Youth AIDS Prevention Project Seventh Grade Curriculum* (also referred to as the *Seventh Grade Curriculum Manual*) provides comprehensive lesson plans for all ten of the seventh grade lessons. Each lesson is prefaced with an outline listing the objectives, activities, suggested time frame and the resources required. Following the lesson outline are detailed summaries and instructions for each activity. "Appendix A: Program Guidelines for the Parent Component" accompanies the 7th grade curriculum. It contains guidelines for conducting the parent workshop. It is presented in a similar format to the manual, with an outline and instructions for the lessons followed by a supplement offering instructors additional information about drugs, adolescent sexual development and behavior, pregnancy prevention and STD/HIV/AIDS. Finally, the manual includes a resource list with telephone numbers for several hotlines (e.g., AIDS, Parents Too Soon) that teachers may want to give students.

The *Youth AIDS Prevention Project Seventh Grade Student Workbook* accompanies the *Seventh Grade Curriculum Manual.* All of the written exercises and homework assignments for the seventh grade curriculum are reproduced in the book with space provided for students (and their parents, when appropriate) to record their answers. At the back of the workbook is a glossary defining key terms that are used throughout the program.

The *YAPP Seventh Grade Activities Cards* are provided for use with the lessons. The cards are clearly labeled and are contained in separate envelopes for the different lessons.

8th Grade Program Materials

The *Youth AIDS Prevention Project Eighth Grade Curriculum* (also referred to as the *Eighth Grade Curriculum Manual*) includes detailed lesson plans for the five-lesson eighth grade booster program. The format is comparable to that described above.

The *Youth AIDS Prevention Project Eighth Grade Student Workbook* accompanies the *Eighth Grade Curriculum Manual*. All of the written assignments for the eighth grade curriculum are reproduced in the book with space provided for students to record their answers. At the back of the workbook is a glossary defining key terms that are used throughout the program.

The *Youth AIDS Prevention Project Eighth Grade Parent Packet* includes brief overviews for all five of the eighth grade student lessons.

The *YAPP Eighth Grade Activities Cards* are provided for use with the lessons. The cards are clearly labeled and are contained in separate envelopes for the different lessons.

Videotapes

"A is for AIDS" videotape. In this 13-minute tape, an animated character describes HIV/AIDS in simple, easy-to-understand language. This is accompanied by a *Supplemental Information on AIDS* pamphlet that provides additional facts which can be used in conjunction with the video.

"Teen AIDS in Focus" videotape. This 16-minute tape describes the lives of five teens who are HIV positive. The tape emphasizes the impact of the disease on the characters' life plans. This is accompanied by a *Teen AIDS in Focus Discussion Guide* containing activities to both precede and follow the videotape as well as some background, goals and purpose about the video.

Teacher Training Materials

The *Youth AIDS Prevention Project Training Workshop Sample Packet* was produced for the training workshop held in conjunction with the original field study in Chicago. The packet includes a description of the project, outlines for the seventh and eighth grade curricula, a summary of research findings, training activities, and fact sheets on topics relevant to class lessons. This packet can guide your own training activities.

The *Youth AIDS Prevention Project Eighth Grade Training Packet* can be used to train teachers who will be implementing the eighth grade booster program. Brief overviews for all five of the eighth grade lessons are provided, along with a few illustrative exercises for students.

Additional Materials

The PASHA program package provides everything needed to implement the *Youth AIDS Prevention Project,* except for the following materials, which should be available in your school or community: a TV and VCR, photocopier or overhead projector, and a cardboard box in which students may place their anonymous questions. Condoms, spermicide foam and vaginal contraceptive film will also be needed for demonstration and practice. The outlines for each session in the two *Curriculum Manuals* list all of the materials needed during that session.

How to Implement the Program

Instructors should review all of the program materials described above prior to the start of the first class lesson. In particular, the *Seventh Grade Curriculum Manual* and the *Eighth Grade Curriculum Manual* both provide full lesson plans for all class sessions.

During the original field study, a one-day training session was held to prepare instructors to implement the curriculum. The instructors were all Master's level health educators who also attended a seminar series to remain informed about current developments in the field of HIV/AIDS. You may want to use the *Youth AIDS Prevention Project Teacher Training Workshop Sample Packet* that was developed for the original training workshop to structure your own training activities. In particular, the project description provides a helpful overview of the project, and the sample exercises introduce teachers to several of the program activities.

Establishing Ground Rules

Ground rules for group discussions should be established at the start of the first seventh grade lesson and again, at the start of the eighth grade booster program. This will help create an atmosphere of trust and comfort in which students feel free to discuss issues concerning sexuality, drugs, and STDs. Hang the Ground Rules poster in a conspicuous spot in your classroom, and discuss each of the following rules.

- Everyone has a right to his/her own opinion and feelings.
- Each individual deserves respect and privacy.
- No one is allowed to "put down" or to laugh at another's ideas or opinions.
- Give the speaker a chance to complete his/her statements (don't interrupt others).
- Questions are both encouraged and important.
- One person speaks at a time.
- What is said in the classroom stays in the classroom.

Importance of Role Playing

Practicing newly-learned skills is a critical piece of the *Youth AIDS Prevention Project*. Because role plays are based on fictional situations, students may say things as actors that they otherwise would not. Therefore, it is important to remind students not to interpret anything said in a role play situation as a sign of interest in having a relationship or sexual intercourse, or in doing anything else depicted in the exercise.

Additionally, instructors will need to keep students motivated and excited about participating in the role plays. The following tips may help.

- Provide structure and direction to students.
- Remind students of the purpose of role play activities.
- Encourage students to use the SAFER method and the six S's resistance/negotiation skills.
- Involve the whole class by having them listen to the skit and provide helpful feedback to their peers.
- Following each exercise, invite students to analyze the decisions made and the skills used.
- Limit the time allotted for each skit so that at least two or three teams have a chance to participate in each role play.

Parent Education Session

The optional parent education session should be held during the seventh grade portion of the program. To encourage parents to attend, you may want to provide child care and refreshments. Suggestions for facilitating the session can be found in the *Seventh Grade Curriculum Manual*

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the *Youth AIDS Prevention Project (YAPP)* was investigated in a field study conducted in 15 school districts in metropolitan Chicago. Research focused on the protective behaviors of students who first became sexually active during the study period. Patterns of parent-child communication, knowledge of HIV/AIDS and intentions concerning protective behavior were also investigated for the entire sample of participants.

Of 45 school districts in the metropolitan area, students in the 15 districts selected for the study were considered to be at greatest risk for HIV infection, based on several behavioral measures, including rates of reported STDs, adolescent pregnancies, school dropout, minority enrollment and poverty. Participating districts were randomly assigned to take part in one of three interventions: (1) the *YAPP* curriculum, including both seventh and eighth grade lessons, as well as parent-interactive activities (5 districts); (2) the *YAPP* curriculum, seventh and eighth grade lessons only, without the parent-interactive component (5 districts); or (3) their own standard AIDS education program (5 districts).

The study began in seventh grade classrooms during the 1991-92 school year, and continued through 1992-93 for the eighth grade booster program. The five districts assigned to use their standard AIDS education programs during the study period typically provided students with either a short (half-day to one-day) informational workshop or a field trip to a health museum. These control group districts were given the *YAPP* program once the field study concluded.

Using results from a self-report questionnaire, the researchers compared both groups of *YAPP* participants with students in the control district schools. To assess the impact of the program over time, questionnaires were administered at three points:

- Time 1: at the start of the seventh grade lessons (pre-test);
- Time 2: at the conclusion of the seventh grade lessons (post-test); and
- Time 3: at the conclusion of the eighth grade booster program (delayed post-test).

Evaluation Questions

Focusing on teens who first became sexually active during the study period, the researchers considered the following question.

- What effect does *YAPP* have on teens' actual practice and intention to practice protective behavior (e.g., use condoms and/or condoms with foam during intercourse)?

Looking at all program participants, the researchers also considered the following questions.

- What effect does the *YAPP* have on parent-child communication?
- What effect does *YAPP* have on teens' knowledge about HIV/AIDS?
- What effect does *YAPP* have on teens' attitudes towards people with AIDS?
- What effect does *YAPP* have on teens' beliefs about their ability to purchase and use condoms and foam?

Data Collection Procedures

Approximately one week prior to the Time 1 (pre-test) assessment, "passive" informed consent forms were mailed to students' parents or guardians in accordance with Illinois law. These forms were to be returned by parents/guardians only if they did not want their child to participate in the program or did not want their child to complete a confidential, self-administered questionnaire. Students were also given the option of non-participation in any part of the project. Refusal rates were less than 1%.

All participating students completed a paper-and-pencil survey under the supervision of trained data collectors—first in the seventh grade and twice more, after they completed the seventh and eighth grade interventions. The survey included questions on decision making, refusal skills, estimates of risk-taking behaviors among peers, attitudes toward people with AIDS, knowledge about AIDS, and patterns of communication with parents and peers. Additional questions asked students about their patterns of sexual activity and knowledge and intentions regarding protective behaviors.

Sample

The intervention sample comprised 2,392 seventh grade students (1,459 treatment and 933 control) who completed the pre-test survey. Because few parents actually took part in the adult activities that had been planned for the parent-interactive intervention, the researchers combined the two groups of *YAPP* participants in their analyses.

Within the original sample of participants, 67% of the treatment group and 70.4% of the control group completed the delayed post-test during the eighth grade. Approximately 58% of these teens were African American, 21% were White and 16% were Hispanic. The researchers also noted that about one-third of the students had become sexually active by the Time 1 (pre-test) assessment in seventh grade.

Approximately 19% of the teens became sexually active for the first time between the Time 1 and Time 3 assessments; this group of students comprised the "newly sexually active students" for whom results are reported below.

Evaluation Results

Newly Sexually Active Students

Protective Behavior

Following the intervention, there were no significant differences between newly sexually active *YAPP* participants and their control group peers in terms of the number of sexual partners or the use of condoms. However, the groups did differ in their use of condoms together with contraceptive foam. At the eighth grade post-test, *YAPP* participants were somewhat more likely to have ever used condoms with foam ($p<.10$). Additionally, on measures of behavioral intentions, 85% of newly sexually active *YAPP* participants, compared to 63% of control group members, reported that they would, or might, use condoms with foam in the future ($p<.001$). The researchers further observed that within the sample, males and Hispanics were more likely to report ever having used condoms with foam. Also, *YAPP* students had a lower frequency of sexual activity and were more likely to have used condoms with foam in the past 30 days, as compared to the control students.

All YAPP Participants

Parent-Child Communication

The *YAPP* curriculum appeared to have a positive impact on students' sense of comfort in discussing both drug use and sexuality with their parents. Yet, students also felt that their parents' feelings about whether they should have sex were less important to them than were their parents' feelings about using illicit drugs (marijuana and cocaine). Moreover, students believed that their parents would be less upset about sexual activity, as compared to drug use, by their children.

Attitudes toward People with AIDS

By the eighth grade assessment, *YAPP* participants showed more tolerance toward people with AIDS.

Knowledge

YAPP participants showed clear gains in their HIV/AIDS-related knowledge following the intervention. In particular, they scored higher than their control group peers on questions about modes of transmission, HIV prevention, the safety of the blood supply, transmission via casual contact, and the reasons for using condoms with foam.

Self-Efficacy

Following the intervention, *YAPP* participants expressed greater belief than their control group peers in their ability to obtain protective products, including condoms and contraceptive foam, from a store or clinic.

Behaviors and Behavioral Intentions

Analyses revealed that the program had no significant effects on actual STD/HIV/AIDS prevention behaviors, such as carrying condoms or using condoms and foam together. Additionally, for the full study sample, no differences were found between *YAPP* participants and members of the control group on the teens' number of sexual partners.

The program did appear to have some effect on teens' behavioral intentions, however. Following the intervention, *YAPP* participants who anticipated being sexually active in the coming year were more likely than their control group peers to intend to use condoms and foam.

Summary

YAPP was designed to educate junior high school students about STDs/HIV/AIDS and encourage sexually active teens to practice protective behaviors. The results of the original program evaluation suggest that *YAPP* appeared to have the greatest behavioral impact on newly sexually active students (those who first began having intercourse during the study period). Compared to their peers in control group schools, this subset of *YAPP* participants was more likely to have ever used condoms with foam, to have used condoms with foam within the past 30 days and to intend to use condoms with foam in the future. *YAPP* students also had a lower frequency of sexual activity in the past 30 days. However, no effects were found on measures of the youths' number of sexual partners nor on the use of condoms alone. Additionally, the intervention did not influence the protective behaviors of students who were already sexually active when the program began.

On other outcome measures for the full sample of *YAPP* participants, the program appeared to improve teens' attitudes towards people with AIDS, factual knowledge of HIV/AIDS, feelings of comfort in discussing sexuality and drug use with their parents, belief in their ability to obtain condoms and intentions to use condoms with foam in future sexual encounters.

Evaluation Materials for *Youth AIDS Prevention Project*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments*, the *Prevention Minimum Evaluation Data Set* (*PMEDS*), and the *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

Student Surveys. The original field study used separate questionnaires for seventh grade and eighth grade students. An additional survey, administered to ninth grade students, was used for subsequent analyses.

The seventh grade survey was administered at the start of the program (Time 1, pre-test) and again at the end of the seventh grade program (Time 2, post-test). Included are measures of HIV/AIDS knowledge, sexual attitudes, self-efficacy, sexual and protective behavior, drug use by self and peers, and attitudes toward people with AIDS.

The eighth grade survey was administered to students at the end of the eighth grade program (Time 3, delayed post-test). It follows a similar structure to the seventh grade survey.

The researchers administered an additional follow-up survey to about half of the students during their ninth grade year. This instrument, though somewhat shorter than the others, includes comparable measures of sexual attitudes, drug use and sexual behavior. More than half of the respondents (57%) completed the survey by telephone, and the rest mailed in their surveys.

Parent Surveys. The parent questionnaires were completed by the parents of students in the *YAPP* program. Separate surveys were developed for seventh and eighth grade parents. Questions measure attitudes and values about AIDS, drug use and sexual activity, as well parent-child communication and parental involvement.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *YAPP*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants of teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

23

Youth and AIDS Project's HIV Prevention Program

An Adolescent STD/HIV/AIDS Prevention Program

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Program Abstract

Title

Youth and AIDS Project's HIV Prevention Program

Summary

A community, clinic and university collaborative launched this program to provide education, peer support, counseling and case management to gay and bisexual male adolescents between 13 and 21 years of age, who are at high risk for HIV/AIDS. The program begins with an interview for individualized HIV/AIDS risk assessment and risk reduction counseling. Youth then participate in an interactive peer education program designed to provide clear, factual information in an atmosphere of mutual support. The program's lessons are reinforced in an educational video. Optional peer support groups meet weekly, if youth wish to attend. Finally, there is a follow-up visit for reassessment and referrals, as needed, to medical and social services. A field study of the program was conducted with a predominantly white sample of males, ages 13-21, who identified themselves as gay or bisexual. Following the intervention, the 139 participants reported less frequent unprotected anal intercourse and more frequent use of condoms. A reduction in substance abuse, particularly amphetamines and amyl nitrate, was also recorded.

Focus

☐ Primary pregnancy prevention

☐ Secondary pregnancy prevention

☑ STD/HIV/AIDS prevention

Original Site

☐ School-based

☑ Community-based

☑ Clinic-based

Suitable for Use In

This program can be implemented by a variety of clinics and community-based organizations serving gay and bisexual teens, providing that necessary medical and social services are available for referrals.

Approach

☐ Abstinence
☑ Behavioral Skills Development
☐ Community Outreach
☐ Contraceptive Access
☑ Contraceptive Education
☐ Life Option Enhancement
☑ Self-Efficacy/Self-Esteem
☑ Sexuality/HIV/STD Education

Original Intervention Sample

Age, Gender	The original sample included 139 males, ages 13 to 21 years (avg.=19.3 yrs.).
Race/ Ethnicity	75% White, 14% African-American, 4% Asian-American, 3% Latino, 3% Native American

Program Components

☐ Adult Involvement
☑ Case Management
☑ Group Discussion
☑ Lectures
☑ Peer Counseling/Instruction
☐ Public Service Announcements
☑ Role Play
☑ Video
☑ Other Optional peer support groups

Program Length

The basic program includes 5-6 hours of activities, beginning with a 2.5 hour risk assessment interview and a 1.5 hour peer education session. Meetings of the peer support groups follow the education sessions; participation in these groups is optional. Three to six months after the basic intervention, a follow-up assessment is scheduled.

Staffing Requirement/ Training

One peer educator (18 to 22 years old) is recommended for every four teens; these educators must be well informed about issues pertinent to gay and bisexual youth. Training includes background information on HIV/AIDS, as well as practice in facilitating group discussions. A psychologist, physician or social worker is needed to perform the risk assessments. Additional professional staff (e.g., physicians, vocational counselors) should be on call to provide necessary services.

How to Obtain this Program

The materials needed to implement and evaluate this program can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). An Order Form is provided at the back of this book for your convenience.

The Program

Program Rationale and History

The *Youth and AIDS Project's HIV Prevention Program* is a combined educational, counseling, case management and peer support intervention. It is specially designed for young males who believe they may be gay or bisexual, identify as gay or bisexual or have sex with other men. At the start of the program, a physician or social worker conducts an individual interview to assess the HIV-risk level of each participant. The professional then counsels the youth about ways to reduce his risk of infection and provides referrals to specialized services, as needed. Afterward, participants attend a peer education session; they may also take part in optional peer support groups for gay and lesbian youth. A final counseling session is held to correct any remaining misinformation the youth might have and to stress HIV/AIDS prevention goals. At this time, if the young person needs additional medical, mental health or social services, referrals and assistance with scheduling, finances and transportation are provided.

A field study of the program was conducted between 1989 and 1991 in Minnesota; a group of 139 gay and bisexual male adolescents ages 13 to 21 participated. Funding for the study was provided by the Minnesota Department of Health and the Maternal and Child Health Program of the Health Resources and Services Administration, Department of Health and Human Services.

Theoretical Framework

The *Youth and AIDS Project's HIV Prevention Program* is based on the finding that gay and bisexual youth—ages 13 to 21—are at elevated risk of exposure to HIV. Their risk is compounded by the practice of anal intercourse, psychosocial problems that fuel risky behavior and few preventive services.

Moreover, the original program developers recognized that gay, lesbian and bisexual youth often struggle to arrive at a positive image of their sexual orientation. At the same time, youth who have established a comfortable identity as a gay, lesbian or bisexual teenager are less likely to engage in high-risk behaviors.

In the absence of a proven model for facilitating HIV risk reduction among this population of teens, the program developers sought to understand short-term changes in gay and bisexual male youths' HIV-related knowledge, attitudes and behaviors. Education, peer support, counseling and case management were selected as strategies to improve youths' understanding of homosexuality and HIV/AIDS, overcome feelings of isolation and reduce high-risk behaviors.

Program Objectives

As an STD/HIV/AIDS risk reduction program, *the Youth and AIDS Project's HIV Prevention Program* is designed to:

(1) broaden participants' knowledge of adolescent homosexuality;

(2) deepen participants' understanding of the psychosocial and emotional problems faced by gay and lesbian teens;

(3) counsel and support participants;

(4) educate participants about HIV/AIDS, including transmission and prevention;

(5) enhance participants' understanding of the adverse effect of alcohol and drugs on HIV risk reduction; and

(6) link participants to any medical, mental health or social services that are needed.

Hypothesized Outcomes

Following their participation in the program, it is predicted that teens will:

(1) be able to distinguish facts from myths about HIV disease;

(2) avoid the use of alcohol and drugs in sexual situations;

(3) communicate clearly with sexual partners about risk reduction;

(4) employ risk-reduction strategies in all relationships;

(5) use condoms consistently during oral, vaginal or anal intercourse;

(6) replace high-risk sexual practices with lower-risk behaviors; and

(7) use HIV antibody counseling and testing, as appropriate.

Program Content

The *Youth and AIDS Project's HIV Prevention Program* combines education, peer support, counseling and case management to increase gay and bisexual males' self-esteem, knowledge about homosexuality and HIV/AIDS-preventive behaviors. Program sessions reinforce the message that in the 1990s in the US, though AIDS is not a gay disease, most HIV infections among both adolescents and adults have been transmitted through unsafe sex between men. Counseling and peer education sessions encourage youth to practice safe sex by using latex condoms lubricated with nonoxynol-9 jelly for anal, vaginal or oral intercourse. Teens are further encouraged not to share any IV drug materials and to avoid exposure to another person's blood, semen or vaginal fluids.

In addition, the program includes group activities to help participants develop new skills for communicating clearly and forcefully in real-life romantic situations. Participants take part in two exercises, one which depicts how rapidly HIV spreads through a tightly knit community of sexually active individuals and the other, which identifies the levels of risk associated with various sexual and drug-use behaviors.

Program Components

The program is divided into three components, ranging in length from 1.5 to 2.5 hours. In the original field study of the intervention, a fourth component—peer support meetings for gay and lesbian youth—were available if the youth wished to participate. You may want to organize a similar activity for your teens.

A brief overview of each component is provided below.

Initial Risk Assessment Interview and Counseling Session

This interview is designed to elicit a detailed evaluation of the youth's HIV-related knowledge, attitudes and behaviors, along with his psychosocial well-being and substance use. Once the assessment has been made, the counselor/case manager conducts individualized education and risk-reduction counseling. Finally, the professional provides referrals, as appropriate, for housing, medical care, further counseling and/or social support groups. The full interview and counseling session typically require about 2.5 hours to complete.

Peer Education Session

Following the risk assessment and counseling session, groups of up to four youth meet for a single 90-minute peer education session. Guidelines for leading this session can be found in the *Peer Education Session* booklet included in the program package. Group members view the video, *Surviving AIDS,* learn about the correct use of condoms and participate in two group exercises. The first exercise asks participants to consider their values about engaging in various sexual and risk-taking behaviors. In the second exercise, teens practice negotiating safer sex in several different situations. During the final part of the session, youth are given the opportunity to ask any questions they may have about HIV and set personal prevention goals. For example, gay youths often raise practical questions such as, "How risky is oral sex?" The peer educators are trained to offer relevant and factual responses.

Final Counseling Session

After the peer education session, the counselor/case manager meets again with each subject to correct any remaining misinformation and to reinforce HIV/AIDS prevention goals. Additionally, if the young person is considered to need additional medical, mental health or social services, the professional refers him to the appropriate agency and helps arrange appointments, finances and transportation, if requested.

Optional Social Support Group

In the field study of the *Youth and AIDS Project's HIV Prevention Program*, a social support group for gay and lesbian young people was available to all program participants. The youth decided whether they wished to take part. In addition to reinforcing program messages about HIV/AIDS prevention, the group provides opportunities for friendship and support. In particular, teens can help one another cope with the homophobia they experience in anti-gay comments, jokes and negative stereotypes, as well as the typical stressors of adolescence. The group can also provide links to such organizations as Parents and Friends of Lesbians and Gays (PFLAG).

Program Materials: Replicating or Adapting *Youth and AIDS Project's HIV Prevention Program*

The *Youth and AIDS Project's HIV Prevention Program* package can be obtained from the Program Archive on Sexuality, Health & Adolescence (PASHA). See the Order Form at the back of the book. The program package includes the following materials needed to implement this program in your community or school. Evaluation materials, described in a subsequent section of this chapter, are also included in the program package.

Program Handbook

Surviving AIDS: Simple Answers to Complex Questions About AIDS and Adolescent Homosexuality (Program Handbook). This handbook is designed for program leaders, both the adult professionals and peer counselors. It contains clear, age-appropriate answers to questions frequently asked by gay, lesbian and bisexual youth. The material addresses adolescence and AIDS, homosexuality, tips and guidelines for working with homosexual youth and AIDS prevention strategies for gay teens. Additional resources are listed in the appendices, such as supportive organizations and related reading for parents, friends and teens themselves. Please note: because the intervention was originally conducted in Minnesota, some of the local statistics and organizations will not be relevant to your program. You may want to provide your staff with appropriate information in their place.

Peer Education Booklet

In the *Peer Education Session* booklet you will find an agenda to guide the 90-minute session, along with a list of necessary supplies. Instructions and role play cards are also included for the group exercises.

Video

Gay Youth and AIDS: Surviving AIDS videotape. This fourteen-minute video, shown during the peer education session, introduces viewers to gay and lesbian youth. The teens talk discuss their day-to-day experiences—their fear, loneliness and depression, as well as their hopes and dreams.

Brochure

What Do These Guys Have in Common? brochure. This brochure was developed and used during the original field study to promote the program, recruit participants and provide information about community resources for gay and bisexual youth. You may want to design a similar pamphlet for your intervention.

Additional Materials

The PASHA program package provides everything needed to implement the *Youth and AIDS Project's HIV Prevention Program*, except for the following materials, which should be available in your clinic or community: a TV and VCR, masking tape, condoms, lubricant and penile models (e.g., cucumbers or bananas). In addition, it may be helpful to have a flipchart and markers available for the peer education session.

How to Implement the Program

Physicians, caseworkers, counselors and peer educators should all preview the *Program Handbook* and *Surviving AIDS* video prior to the first session. In addition, you will need to train the youth leading the peer education session. In the original field study of the program, training included background information on HIV/AIDS, as well as practice leading group discussions. The educators were gay and bisexual males, ages 18 to 22, who had been nominated by members of the Youth and AIDS Project's social support groups. These youth were selected for their sensitivity to issues concerning adolescence, homosexuality and HIV/AIDS.

Obtaining Necessary Support

The subject matter of the *Youth and AIDS Project's HIV Prevention Program* can be controversial. Before implementing this program—or any STD/HIV/AIDS prevention initiative—make certain that you understand and apply all policies and mandates relevant to your clinic or community organization.

Establishing Ground Rules

Ground rules should be established at the start of the intervention and followed by all physicians, caseworkers, counselors, peer educators and youth involved in the program activities. This will create an atmosphere of trust and comfort in which participants feel free to discuss sexuality and protection from sexually transmitted disease.

The procedures listed below have been adapted from recommendations drafted by Parents and Friends of Lesbians and Gays (PFLAG). They are printed in the *Program Handbook*.

(1) Do not act surprised when someone tells you they think they may be gay, lesbian or bisexual. The person has decided that you can be trusted and helpful. Do not let him or her down.

(2) Respect confidentiality. Gay, lesbian and bisexual teenagers who share their identity with you have established a sacred trust that must be respected.

(3) Be supportive. Let gay, lesbian, or bisexual teenagers know that they are "okay." Explain that many people have struggled

with the issue of homosexuality. Acknowledge that dealing with one's sexuality is difficult. Keep the door open for further conversations and assistance.

(4) Assess his or her understanding of homosexuality. Replace mis-information with accurate knowledge. Don't assume that gay, lesbian and bisexual teens know a lot about human sexuality. We have all been exposed to myths and stereotypes, so it is very helpful to provide clarification.

(5) Read reliable references and talk to qualified persons. Know the community resources available to provide gay, lesbian, or bisexual youth with social support and information.

(6) Deal with feelings first. Most gay, lesbian and bisexual teenagers feel alone, afraid and guilty. You can help by listening and allowing them to unburden uncomfortable feelings and thoughts.

(7) Examine your own biases so that you can remain a neutral source of information and support to the youth.

(8) Use non-judgmental, all-inclusive language in your discussion. Pay attention to verbal and non-verbal cues. Do not label or categorize.

(9) Anticipate some confusion. Many gay, lesbian and bisexual teenagers are sure of their sexual orientation by the time they enter high school. Others will be confused and unsure.

Evaluating the Program

The Original Evaluation

Design

The effectiveness of the original *Youth and AIDS Project's HIV Prevention Program* was investigated in a field study conducted in Minnesota between 1989 and 1991. A group of 139 male adolescents, ages 13 to 21, participated; all identified themselves as gay or bisexual.

The evaluators used a diverse set of measures to study changes in the teens' knowledge, beliefs, attitudes and behaviors over time. Questionnaires were administered to all teens twice during the study period:

Time 1: At the initial assessment interview (pre-test); and

Time 2: Three to six months following the initial interview (post-test).

Evaluation Questions

The researchers investigated whether program participation was associated with changes in the youths':

- friendship patterns;
- knowledge of and attitudes toward HIV/AIDS;
- patterns of sexual activity, especially high-risk behaviors;
- use of condoms; and
- substance use/abuse.

Data Collection Procedures

A number of strategies were employed to recruit participants for the study. The researchers placed advertisements in gay publications and businesses, spoke at social and community meetings and sought referrals from school and health professionals and previous participants in Youth and AIDS Project activities. Eligible youth were male, between the ages of 13 and 21, who either identified themselves as gay or bisexual, regardless of their sexual behavior, or reported having sexual intercourse with men.

Because no comparison group was used in the study, all participants received the same intervention. That is, they took part in individualized risk assessment, peer education and counseling/case management sessions. Youth with special needs were referred to appropriate medical and/or psychosocial services and assisted with scheduling and transportation arrangements.

Participation in the study and the program were voluntary and confidential. The youth provided verbal and written consent for each component, but parental consent was not required. At their initial risk assessment interview, a number of instruments were administered to the youth, both self-report surveys and structured interview questions. These measures were re-administered at the follow-up assessment session, which took place between three and six months later. On average, 4.75 months elapsed between the Time 1 and Time 2 assessments.

Youth received $20 for attending the initial risk assessment interview and peer education session and $10 for the follow-up interview; they were also eligible to receive a $5 bonus for each friend referred for an interview.

Sample

Of the 239 youth who took part in the initial assessment interview, 41 were unable to complete the Time 2 measures. Of this group, 24 had moved out of state and the remaining 17 entered the program too late to allow for a follow-up assessment. Complete data were available for 139 teens, ages 13 to 21 years. The great majority of the sample (91%) identified themselves as gay, and the rest as bisexual. At the time of the study, the typical youth was 19.3 years old and had completed twelfth grade. About three-fourths of the participants were currently enrolled as students. The evaluators found no significant differences in background characteristics or frequency of sexual intercourse between those teens who did and did not take part in the two assessments.

Reflecting the demographic characteristics of the region in which the program was located, the final sample was largely White (75%). Other racial/ethnic groups represented in the study included African-American (14%), Asian-American (4%), Hispanic (3%) and Native American (2%).

Evaluation Results

Participation in the *Youth and AIDS Project's HIV Prevention Program* was associated with a number of positive outcomes, including reductions in HIV risk behaviors.

Effects on Knowledge and Attitudes

Participants scored well on measures of basic HIV etiology and transmission at both assessment periods. At Time 2, the youth were more likely to know that "AIDS causes other diseases" and that the HIV antibody test is not "a test for AIDS."

Additionally, both before and after the intervention, participants generally reported realistic beliefs about the risk levels of various sexual behaviors.

Effects on Friendship

The *Youth and AIDS Project's HIV Prevention Program* was designed, in part, to reduce feelings of isolation and alienation among gay and bisexual youth. Following the intervention, teens reported an increase in the proportion of their friends who were bisexual and homosexual, and nearly half (43%) had revealed their own orientation to more friends. Additionally, a larger number of participants were living with another bisexual or homosexual person, but the percentage of teens who were involved in a steady relationship was unchanged.

Effects on Substance Use

A summary measure of the severity of teens' substance abuse showed significant improvement following the program ($p<.001$). Although the youth did not significantly modify their use of alcohol, marijuana or binge drinking, their use of amphetamines ($p<.011$) and amyl nitrites was significantly lower at the Time 2 assessment ($p<.05$).

Effect on Sexual Behavior

Overall, the researchers found that bisexual behavior diminished over time, while homosexual behavior remained relatively steady. Among participants who were sexually active at both assessment periods, there were no significant changes in the number of sexual partners. However, at the Time 2 assessment, more than one-third of the teens showed a significant drop in their rates of insertive and receptive anal intercourse with male partners ($p<.0001$).

Use of Condoms

Changes in teens' use of condoms varied for different forms of intercourse. At the Time 2 assessment, teens reported more consistent use of condoms during anal intercourse; in fact, the rate of unprotected anal intercourse dropped by 60%, and 78% of the youth reported consistent use of condoms during anal intercourse with new partners ($p<.005$). Yet, no change was recorded in the use of condoms during oral sex, and the trend for vaginal intercourse fell short of significance ($p<.07$).

Effect on Ongoing HIV Risk

"High risk" for HIV transmission was defined as any unprotected anal intercourse or shared use of needles or syringes with any partner since Time 1. Overall, 35 participants (25% of the sample) were found to be at high risk during the follow up. These included all persons who continued, started or relapsed into risky behaviors, notably receptive and insertive anal intercourse without condoms and shared use of needles or syringes.

The high-risk teens differed significantly from the rest of the sample on a number of characteristics. In particular, they were less likely to be enrolled in school and reported that a larger proportion of their friends were gay. They also reported engaging in more frequent anal intercourse with a greater number of partners than their lower risk peers.

Summary

Findings from the field study document short-term changes associated with participation in the *Youth and AIDS Project's HIV Prevention Program*. In particular, youth showed significant reductions in their frequency of high-risk sexual behaviors, including insertive and receptive anal intercourse with male partners, and unprotected anal intercourse. Teens' severity of substance abuse also declined.

Overall, the researchers found that anal intercourse, and to a lesser extent, oral sex were the two practices youth were mostly likely to change. Moreover, the teens employed both risk-avoidance and risk-reduction strategies. Some teens used condoms to prevent HIV transmission during anal intercourse, while others abstained from this sexual behavior. Alternatively, they practiced oral sex in place of other, more dangerous behaviors.

Nevertheless, one-quarter of the participants remained at high risk for HIV transmission at the follow-up assessment. It appeared that youth most in need of condoms were the ones least likely to use them.

In interpreting their findings, the researchers noted that the absence of a comparison group prevented any causal attribution about their program. In other words, they were unable to determine whether the observed outcomes were due to program participation, or other factors (e.g., maturation, information the teens received from other sources).

Evaluation Materials for *Youth and AIDS Project's HIV Prevention Program*

In addition to the program materials described in an earlier section, the PASHA program package includes three evaluation resources: the *Original Evaluation Instruments*, the *Prevention Minimum Evaluation Data Set (PMEDS)*, and the *Local Evaluator Consultant Network Directory*. These materials are included to encourage the replication and re-evaluation of this promising program in new sites, with new groups of teens.

Original Evaluation Materials

The following three questionnaires were used in the field study of the program and are included in the program package:

AIDS Knowledge and Attitudes. This self-administered, paper and pencil survey is designed to assess teens' knowledge about AIDS and the HIV antibody test and probe their beliefs about HIV transmission. The instrument contains 51 items.

Risk Assessment Survey. This structured interview includes 184 multiple-choice and open-ended questions. The items probe teens' personal and family background, current housing situation, educational and employment status, sources of social support, health and psychosocial status and sexual history.

Substance Use Inventory. This 55-item, self-administered instrument includes questions on the use of alcohol, tobacco and other drugs, as well as the impact of these substances on the respondent's physical and emotional well-being.

Alternate Evaluation Materials: PMEDS

Also included in this package is *Prevention Minimum Evaluation Data Set (PMEDS)*, a generic instrument that you should consider using as an alternative to the original evaluation instruments. *PMEDS* can be used to evaluate a variety of teen pregnancy and STD/HIV/AIDS prevention programs, including *Youth and AIDS Project's HIV Prevention Program*. It is designed for self-administration with teens between 13 and 19 years of age, and incorporates standardized measures of participants' knowledge, behaviors, and attitudes. *PMEDS* may enable you to compare your data with that of other prevention programs and can help you reinforce the quality of your evaluation through the use of scientifically-tested questions. The *PMEDS* booklet describes the goals, development and content of the questionnaire and provides instruction on how to tailor the questionnaire to suit your particular program.

Consultant Directory

The *Local Evaluator Consultant Network Directory* provides the names, addresses, institutional affiliations, and phone numbers of experts who can serve as evaluation consultants of teen pregnancy and/or teen STD/HIV/AIDS prevention programs. The list is organized alphabetically, first by state, then—within each state—by consultant's last name.

Program Archive on Sexuality, Health & Adolescence (PASHA)
Order Form

Primary Pregnancy Prevention Programs

Quantity	Program Name	Price*	Total
	Human Sexuality-Values & Choices...	$315.00	
	Project TAKING CHARGE	$960.00	
	Reducing the Risk	$195.00	
	Reproductive Health Counseling for Young Men	$195.00	
	School/Community Program for Sexual Risk Reduction Among Teens	$125.00	
	School-Linked Reproductive Health Services (The Self Center)	$195.00	
	Tailoring Family Planning Services to the Special Needs of Adolescents	$195.00	
	Teen Talk	$195.00	

Secondary Pregnancy Prevention Programs

Quantity	Program Name	Price*	Total
	A Health Care Program for First-Time Adolescent Mothers and their Infants	$125.00	
	Queens Hospital Center's Teenage Program	$125.00	

STD/HIV/AIDS Prevention Programs

Quantity	Program Name	Price*	Total
	Adolescent's Living Safely: AIDS Awareness, Attitudes and Actions	$250.00	
	Adolescents Living Safely: ...for Gay, Lesbian & Bisexual Teens	$270.00	
	AIDS Prevention and Health Promotion among Women	$195.00	
	AIDS Prevention for Adolescents in School	$195.00	
	ARREST: AIDS Risk Reduction and Skills Training Program	$195.00	
	AIDS Risk Reduction for College Students	$325.00	
	A Clinic-Based AIDS Education Program for Female Adolescents	$275.00	
	Get Real about AIDS®	$620.00	
	Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth	$195.00	
	Rikers Health Advocacy Program (RHAP)	$195.00	
	Safer Sex Efficacy Workshop	$195.00	
	Youth AIDS Prevention Project (YAPP)	$590.00	
	Youth and AIDS Project's HIV Prevention Program	$195.00	

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